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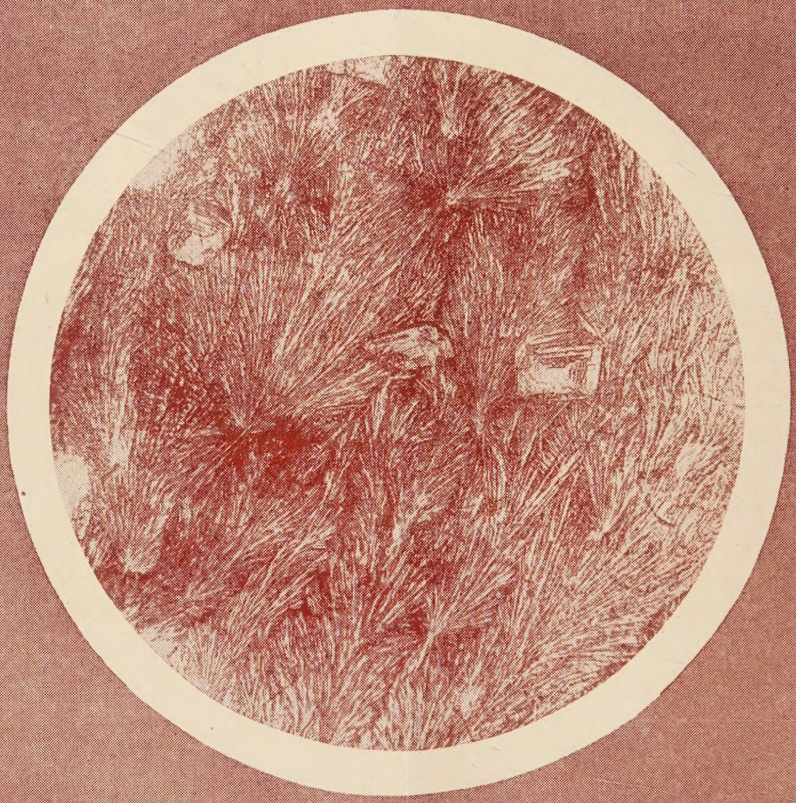
Symposium on Neuropsychiatry, page 287

May 1945

Vol. 158, No. 5

This is one of a series of historical notes, highlighting important achievements in Vitamin Research. Illustration is from unretouched photo-micrograph taken in 1944.

GREAT TRIUMPHS IN VITAMIN RESEARCH



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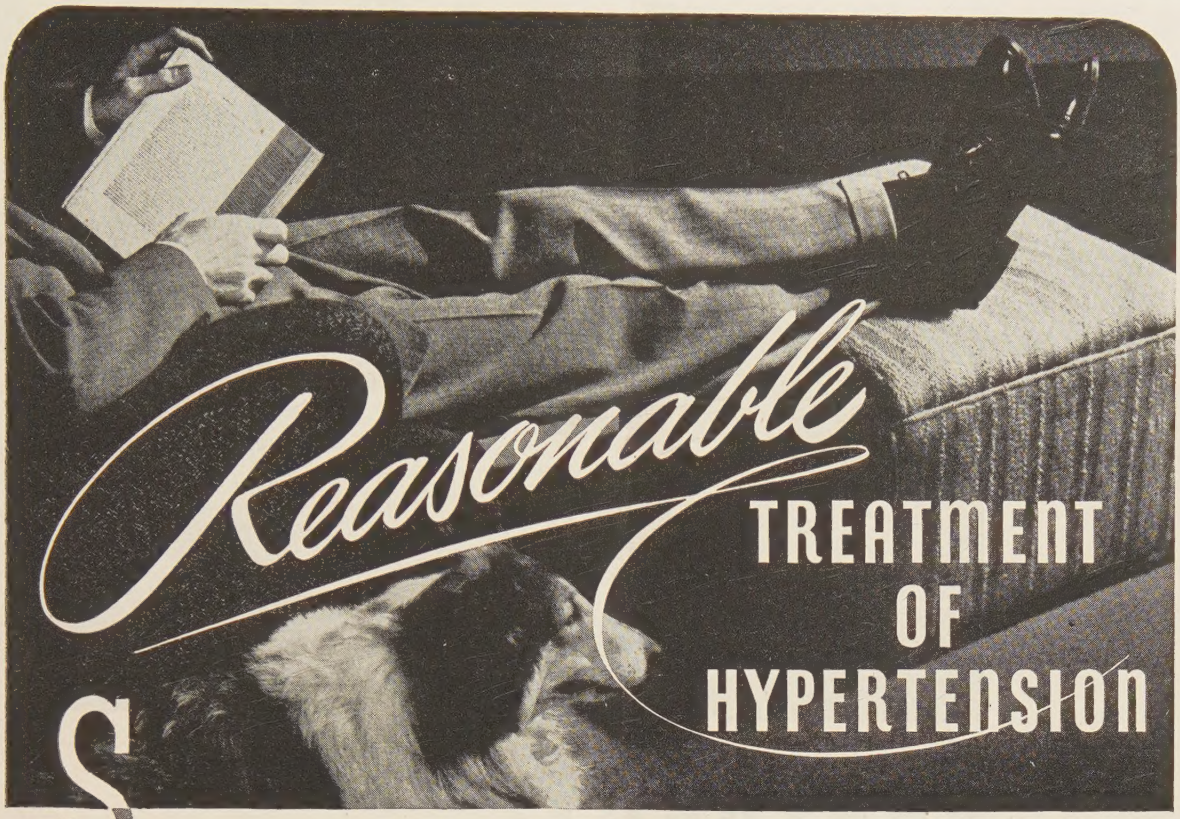

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Medicine in Ancient Mesopotamia

The civilization of the Sumerians, the oldest and the most important of western Asia, was at its zenith 3000 B.C., says the *Medical Journal of Australia*. Their medicine, animistic and sacerdotal, was based on astrology, and prognosis and treatment depended upon the guidance of the stars. The centre of Sumerian civilization was the temple, and the king, who was also the high priest and the chief of the magicians, was from that fact the grand master of the doctors. Treatment was based on physical and spiritual hygiene. Water and fire were the chief purifying agents. Mesopotamia was conquered by the Accadians 2500 B.C., but Sumerian culture survived and remained the foundation of Assyro-Babylonian civilization. Clay tablets from the library of King Assur-bani-pal of Assyria and the code of King Hammurabi of Babylon, at present in the Louvre, are remarkable documents from the medical point of view. From the seals of one or two great physicians we learn that certain doctors were appointed to positions of importance in the State. Moreover, the letters of the most famous doctors of the Assyrian court are available; from them we learn of their medical doctrines. Their medicine, like Sumerian medicine, was sacerdotal, and was practised by doctor-priests. The legends all point to the Assyrians' symbolic attitude to life and to their constant preoccupation with immortality. According to their belief, man was the son of the god who gave him life. Thus, if a man fell ill, he had to call upon one of the creator gods and ask of him deliverance from his trouble and purification from past sins (for illness was always the result of sin or impurity). Brought about by one of the countless demons and malign spirits that haunted the imagination, or by an evil spell cast by a sorcerer, the sickness had to be combated by natural and magic means. The doctor's task, as soon as he was called to the patient, was to discover the causes of the illness. He inquired into past misdemeanors, into the patient's thoughts, into his fears of being possessed. The doctor then decided upon the nature and extent of the "demon illness". If the doctor was unable to solve the mystery of the illness, recourse was had to divination. Examination of the stars, the interpretation of dreams and the offering of sacrifices, were carried out with scrupulous attention to ritual and in accordance with tradition. When a sacrifice was offered, the organs were examined; the first thing noted was the state of the liver, which is believed by all oriental peoples to be the vital organ, and which the Chaldeans held to be the seat of the soul. Another type of investigation was pouring oil on water and noting the various patterns that it made.

When a diagnosis was made, treatment consisted first of all in reconciling the patient with his god, and then the "demon illness" could be driven out. Prayers and invocations to the angry gods were followed by certain purifying rites and by expiatory sacrifices, a kid or a lamb being offered. The patient was sprinkled with fresh water, "washed of his sins", and the illness was destroyed by magic forces, as fire burns and purifies a handful of grains of wheat. Then at last, good health, evidence of a blameless life and of the presence of his god in the man, was once more restored. He who obeyed the divine law and led a life free from sin should remain in health and live long.

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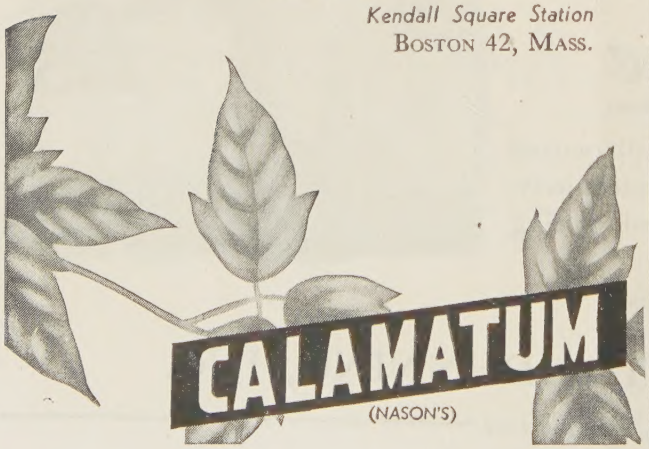

Open Forum

THE PHYSICIAN AS HEALTH EDUCATOR

BRUNO GEBHARD, M.D.
Director, Cleveland Health Museum
Cleveland, Ohio

The public gets too much of its health education from such marvelous sources as radio plugs, magazine advertisements, streetcar cards, window displays—all dinning a different message. Much of this free information is apparently directed at simpletons.

Here are a few "diseases" which have been invented to scare people into buying a preventive product: Underarm offensiveness; pendulosis; hi ten sitis; body odor; paralyzed pores; intestinal toxity; colon collapse; ashtray breath; office hips; pink tooth brush. These are merely jazzed up and modernized versions of such ancient misinformation-pieces as "An apple a day keeps the doctor away."

On the brighter side, we find official and voluntary health agencies doing public health education on a scientific, planned basis. They have achieved creditable success in at least two lines:

1. The decrease in tuberculosis. Progress in medical science had to come first, but the successful cooperation of the public was realized only after the health workers put over their educational campaign.

2. The decrease in infant mortality, through education of the mothers, better care of babies, and early medical supervision. All this is on a voluntary basis. No one forces the mothers to see their doctors, eat protective foods, or sterilize the nursing bottles. Again the answer is education . . . for cooperation.

This is the type of health education we must work to increase and broadcast.

As far as the individual physician is concerned, he has always been a health educator to his patients, as indicated by the original meaning of the word doctor—teacher. But, alas, this personal relationship is not always satisfactory. Patients often complain that their doctors answer questions briefly and indifferently, leaving them confused and resentful. An anonymous letter to the *Atlantic Monthly* of June, 1940, reads in part:

"Many doctors will do anything in the world for a patient or his family—except treat them as responsible adults. The doctor . . . tells the patient and family only what he thinks good for them to believe. But in order to stand by intelligently and not just foolishly, in order to cooperate with the doctor in every possible way, the family must have some idea of what it is all about. It is their right and their duty." This letter was reprinted in the *Reader's Digest* under the caption, "Patient's Plaintive Plea".

Another question, dropped into the Cleveland Health Museum's Question Box, reveals one woman's bewilderment: "What is the best means of finding the doctor who best fills one's particular need? Are there any physicians in Cleveland who work at keeping people well rather than curing them after they are sick?"

We can only speculate at the experience which prompted such an inquiry. Directly or indirectly, *all* physicians work at keeping people well. But who is to blame for this obvious lack of understanding? Pos-

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sibly the answer lies in the medical college's curriculum, which touches on everything except normal psychology. The assumption is that the selection of a medical career is in itself a guarantee that the student already possesses the human-interest, the tact, and the insight which are so valuable in the practice of medicine.

Some steps have been taken at the Western Reserve School of Medicine in the right direction. Students in the Department of Public Health visit local health agencies, including the Health Museum, to observe the techniques employed with the public. At the Museum they hear a lecture on "The Physician as Health Educator", and write a critical report. Slight though it is, this tour and lecture are a beginning toward the goal—which is to make the doctor consciously a health educator.

Another gap between the doctor and his patient is that of language. Too many practicing physicians are overly-professional in their terminology. Such turgidity is excellent—if you intend to keep the patient's head whirling. But what is the advantage of using the Latin name? I see none.

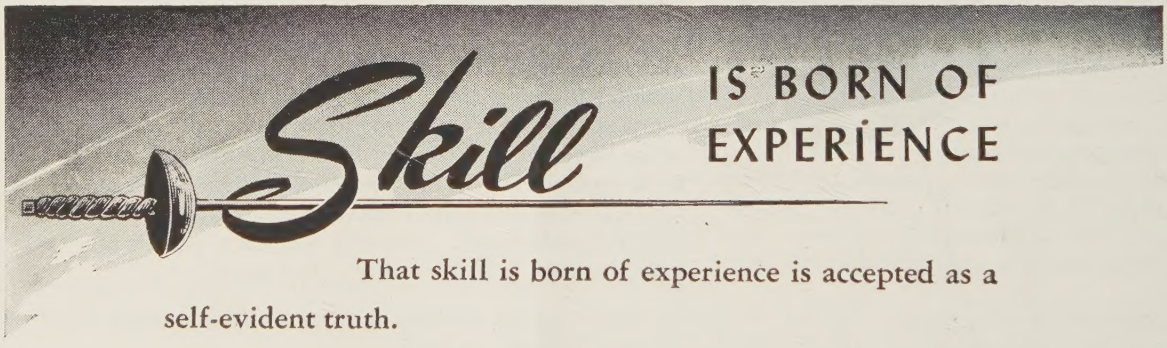
Every trade has its own lingo, remote from everyday conversation. The general public can't be expected to understand such specialized phrases or be aware of specialized meanings of ordinary words. A fifth-grade girl one day came home from school crying, after the school doctor had made an examination. She wailed, "Something must be wrong with me. Maybe something is even missing. My heart is not all right. We had the Doctor this morning, and he said my heart is only negative!" To the little girl, "heart negative" had only unhappy connotations. No wonder she came home crying. The change of one word would make all the difference in the world. Let us make it, wherever possible, "heart positive".

A great puzzle to many people is how to choose a doctor. Presumably some open the telephone book, close their eyes, and make a mark with a pencil. Think of the chances they run of seeing a podiatrist instead of a pediatrician; an optometrist instead of an ophthalmologist; or even a chiropractor instead of a chiropodist! It almost seems as though doctors deliberately attempt to shroud themselves and their practices in mystery. The age of mysteries is gone. Frank and open public relations have taken their place!

Some physicians may argue that health education of the public increases hypochondria and leads to self-diagnosis. I do not agree. People born with such tendencies will become hypochondriacs with or without health education. In fact, a suspicion that the doctor is concealing facts undoubtedly can increase the tendency. Honest health education, on the other hand, relieves anxieties and encourages a more optimistic outlook.

As for the dangers of self-diagnosis, the fact has been and always will be that the primary diagnostician is the sufferer, himself; otherwise he would not make the first step in the treatment, which is to see his doctor. After that, of course, it is up to the doctor to continue the treatment.

All this points inevitably to the need for continued, authentic health education, to counterbalance the unceasing commercial activity on behalf of the too-many pills, powders, and purges that are sold so glibly to



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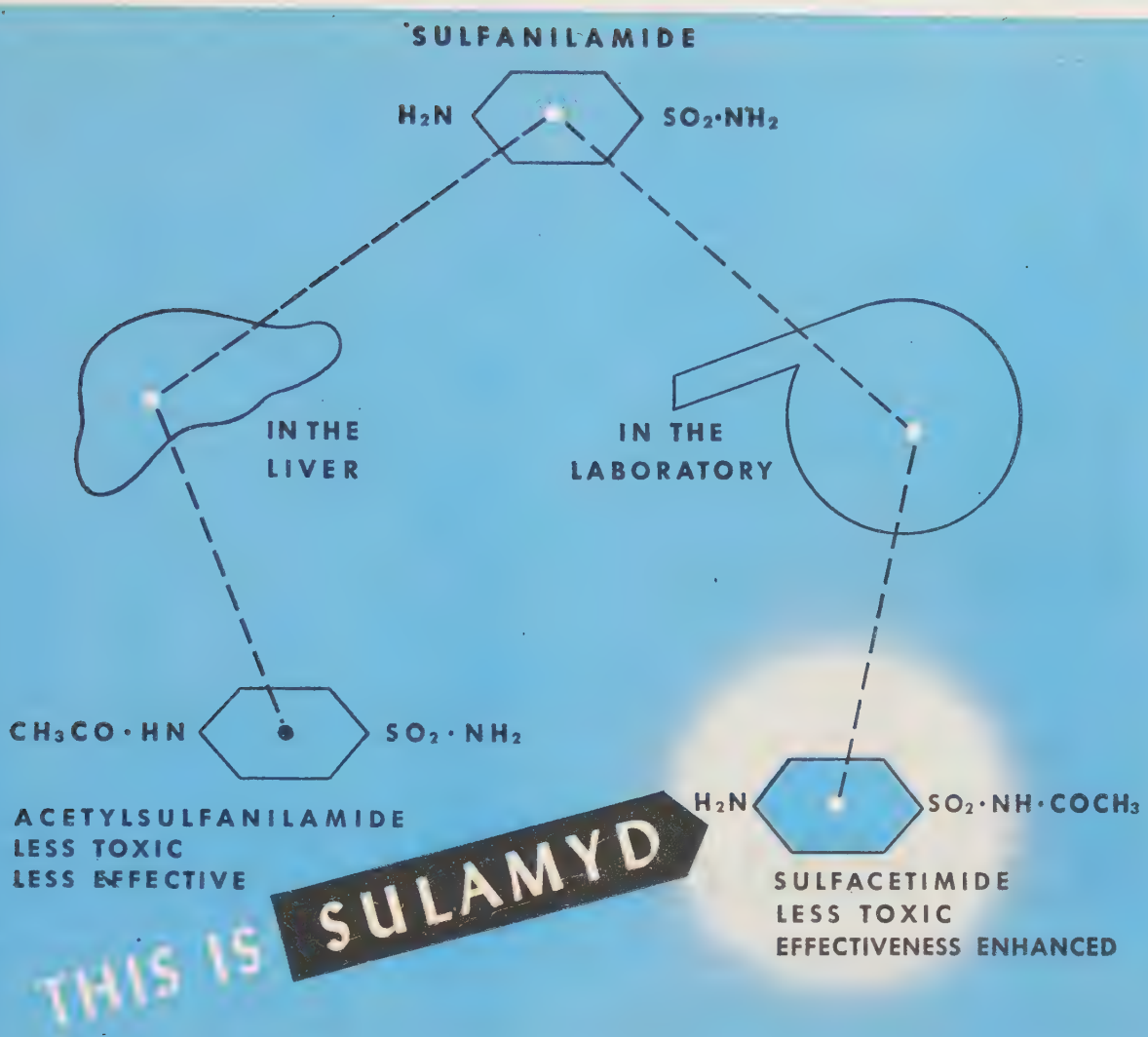

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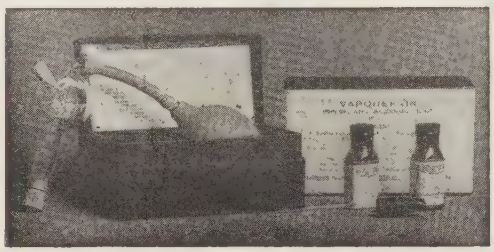

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the American public. Interest already exists. All that is needed is to satisfy that curiosity with the truth. Every new discovery in treatment, diagnosis, or technique has increased the demand for better medical service.

The function of the Cleveland Health Museum is to tell the truth. It is not an advertising agency for the medical, or any other, profession. At the same time, there is no doubt that merely by pointing out the truth, it does for the medical profession the same thing done by the insurance companies' advertising on behalf of accident prevention.

Ethics forbid the physician to offer his services. On the other hand, many sufferers believe their questions and worries are too foolish or unimportant to mention. The Health Museum, with its exhibits emphasizing the complexity and importance of care of the body acts as a middleman. Questions that the patient hesitates to ask his doctor may be written on blank forms and dropped into the Question Box, to be answered by mail from the Bureau of Health Education, A.M.A.

Most patients are adults. They have been through both good and bad experiences with doctors. It takes a number of good experiences to cancel out one distasteful memory but it can be done. Doctors interested in the cooperation of their patients have this on their side: most people at heart have faith in the medical profession and in science. If we don't educate them in the name of science and medicine, who will? You all know the answer.

To those of you who vow to rush out and buy a ten-foot-square colored diagram of the circulatory system to hang in your waitingroom—Stop! Don't upset your patients with such a large and unappetizing slice of health education served all at once, and on an empty stomach. The technique of health education requires more subtlety than that.

Applied health education, like other treatments, requires the right diagnosis, then the correct doses of the proper medicine. You must call on all your tact and character-reading ability to give the patient information that will encourage his spirit as the medical dose strengthens his body.

Do not consider it a "shock" treatment. Think of it as a kind of convalescence, in which the patient gets a small degree of help each day for a long time, until the goal is reached. That goal is perfect understanding and faith between you and him.

Penicillin Treatment of Leprosy

G. H. Faget and R. C. Pogge report the unsuccessful use of penicillin in the treatment of seven cases of leprosy at the National Leprosarium, Carville, La. *Public Health Reports* (March 23rd) present a summary of their findings, with brief case histories of four patients. The complete article, entitled "Penicillin Used Unsuccessfully in Leprosy" will appear in the forthcoming issue of the *International Journal of Leprosy.* In the seven cases reported the patients were given penicillin in doses of fifty to one hundred thousand units of penicillin daily, continued in some cases for a month. No specific beneficial effect could be attributed to this treatment either during the course of medication or for six months thereafter. The authors conclude that penicillin in doses even larger than those usually found adequate in syphilis is ineffectual in leprosy.

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A Great American Scientist Reminds Us of Our "Defeat"

In the *American Scholar*, a magazine which is the official organ of the Phi Beta Kappa Society, Dr. Harlow Shapley, head of the Observatory at Harvard College and one of the world's greatest astronomers, has published an article* which he read before the American Association for the Advancement of Science at its latest convocation. Occupying an important place in his essay, Dr. Shapley has made some trenchant observation on public health medicine which should be of great interest to everybody—physician and layman alike. It is with the special permission of Dr. Shapley that the MEDICAL RECORD reprints the section having to do with what he calls

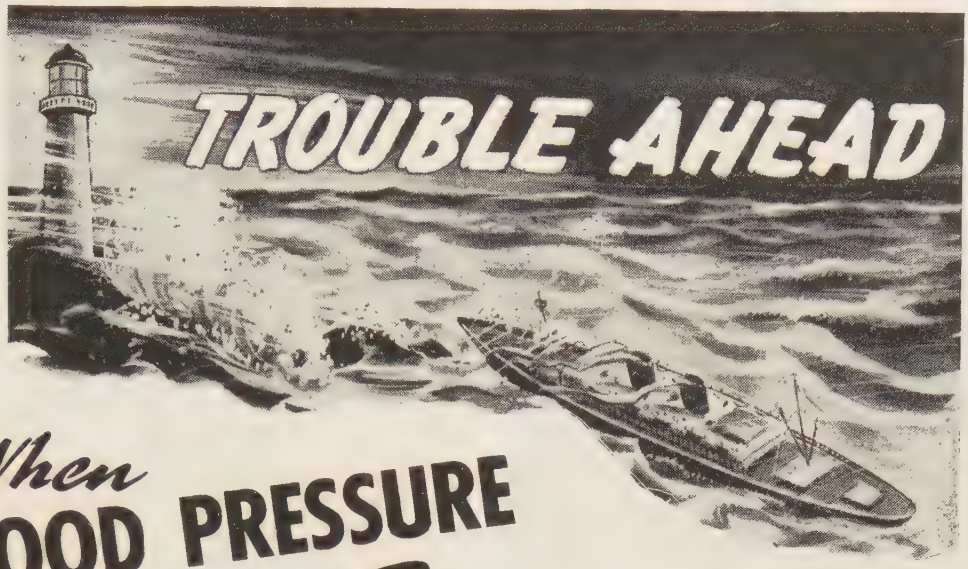
Our Recent Inglorious Defeat and Humiliation

"In 1918-19 more than four times as many Americans were killed by influenza as by our enemies of the first World War. Twenty million humans perished of that ruthless disease. The economic loss in the world-wide battle with the influenza organism was also tremendous. Moreover, sad and shameful to say, we lost that war. We, the highest and most resourceful animals on the face of the earth, came off battered and disgraced, with the enemy hardly scratched. Only when it became satiated with its successes did the savage fiend recede into the invisible realms where it normally dwells, and from which it has at times made further minor forays with murderous and economically destructive results. Even yet, that adversary is not defeated; our Maginot lines against it are permeable and insufficient.

"Clearly we have right here a dangerous enemy for our next war. Why are we not all arming ourselves against this treacherous foe that does not hesitate to make sneak attacks, and has no respect for armistice? There were several millions of us engaged in those influenza battles of 1918-1919; and *we* are the casualties who recovered. I now wonder why in heaven we who returned from these battlefields did not form an American Flu Legion, don our old face masks and march in parades, brandishing our voting strength, and influence congressmen. With our political power under the leadership of General Doctor, Captain Laboratory Technician, Lieutenant Nurse—all who fought valiantly with us millions of private sufferers in the great influenza war—with that power we might have got the government to fortify research laboratories munificently, drill the citizens in epidemic prevention and control, enforce the care of body and mind, and turn the powerful mass psychology into a fervent patriotic assault on the enemies of mankind that have always been more deadly than the soldiers of European fanatics and tyrants. But, alas, we did not organize. Medical investigators and public health officers continue to do their best, without much government or public support, while the undertakers year after year continue to tuck us away prematurely."

The medical profession would willingly glorify these words and help them to be translated into action. We say: On with this new war!

*American Scholar, 14:1, 23, 1945.



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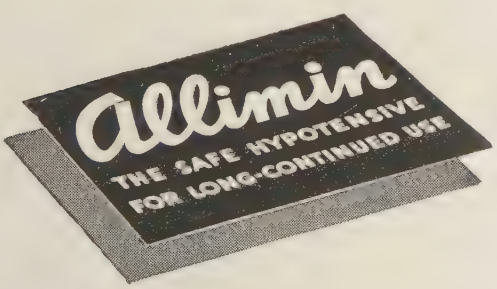

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Enforced Leisure

In a study of the activities of officer prisoners of war, A. R. Dearlove (*British Medical Journal,* March 24, 1945) estimates the value of the contribution the average prisoner makes to the life of the camp. A questionnaire covering all possible forms of camp activity was sent to the camp as a whole and the author believes that the returns represent a fair cross-section of the camp. His general conclusions are as follows: Under wartime conditions most people are forced to "waste time" in the sense that individual studies and careers are interrupted. The prisoner of war, in this respect, is no worse off than anyone else, except that he has leisure which, although unlimited in time, yet in space is strictly limited. He utilizes this in activities which may be roughly grouped under three headings:

First, work, which includes official and altruistic activities, study and fatigues amounting to about five hours a day per head. Second, vegetative and—predominantly—time-consuming activities, which are represented by sleeping and eating, gossip, card-playing, and unaccounted time, amounting to about fourteen and a half hours a day per head. Third, creative and recreational activities, such as art, music, handicrafts, writing, dramatics, reading, hobbies, sport, and lectures, amounting to about four and a half hours a day.

The general impression of the author was that the physical and mental well-being of the prisoner of war largely depended on his daily activities and, of course, conversely. This was strikingly illustrated by the case of an ex-schoolmaster who worked conscientiously six hours a day for three years, passed two difficult examinations, and then suddenly developed sciatica and polyneuritis, which incapacitated him for further study. In replies which devoted most time to vegetative and time-consuming pursuits, there was a greater tendency to admit physical and mental impairment or to complain of symptoms for which an organic basis could not be found. This might represent a "prisoner of war neurosis" and will presumably disappear when the conditions causing it are removed.

Violations of Narcotic Laws

Violations of narcotic drug laws have decreased continuously during the past five years, according to the 1944 annual report of the Department's Bureau of Narcotic Control, Ralph M. Wyman, chief (*Health News,* March 26, 1945). Restriction of the activities of drug addicts through stringent laws and regulatory measures and the decline in smuggling attendant upon war-restricted shipping facilities are believed to have been potent factors in reducing the number of offenses to a point well below the one thousand mark both in 1943 and 1944.

Narcotic drug law violations in the State last year totaled 740 compared with 733 in 1943, a decrease of four percent in contrast with a reduction of sixteen percent in general crimes for the corresponding period. The probable explanation of the slight decline in narcotic violations is that all known offenders rejected for military service have remained in the civilian population. Apprehensions numbered 738, almost one hundred percent, compared with 773 offenses and 762 arrests in the preceding year. A total of 829 narcotic cases, including about one hundred held over from 1943, was disposed of in the courts of the State—sixty-three for felonious sales and 766 for misdemeanors.

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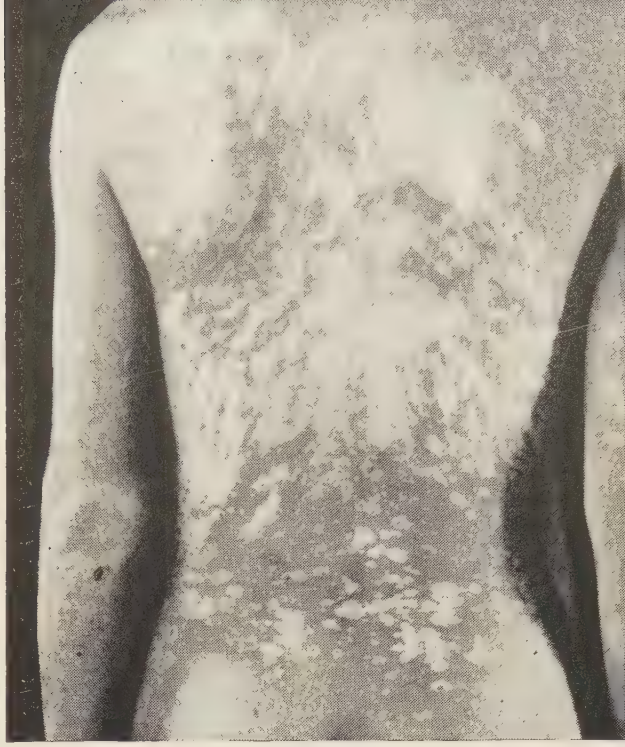

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The Control of Yellow Fever

M. V. Hargett (*Puerto Rico Journal of Public Health and Tropical Medicine,* September, 1944) says that extensive reservoirs of yellow fever exist in Africa and South America, and that portion of Panama situated between Colombia and the Panama Canal probably harbors the disease. No other infected regions are at present known. Europe and North America, though repeatedly invaded during the past, have been free for a great many years. The disease has never in historical times appeared in Asia, Australia, or the Pacific islands.

The danger of yellow fever becoming established in currently free but infectible regions as a result of virus introduction is a present public health problem of major international importance. The four most useful criteria for detecting yellow fever in man are the clinical manifestations, the distinctive pathology of the liver in fatal cases, the development of specific virus-neutralizing bodies in the blood where none existed previously, and the identification of the etiological virus. While elimination of Aedes aegypti and vaccination are of major value in the eradication of yellow fever, the following listed measures are of importance and demand the attention of physicians and sanitarians, who are or may be confronted with the disease:

(a) Mosquitoes should be kept from the yellow fever patient during the first three days of illness to prevent the infection of any that might otherwise feed on him, become infected, and subsequently transmit the disease. (b) Blood, or fractions thereof, coming from yellow fever patients during the initial three days of illness contain the yellow fever virus and should be handled with caution by persons not immune to the disease, as simple cutaneous contact with such material may cause infection. (c) Persons coming from yellow fever areas, who desire to enter free but infectible countries and who may harbor the virus of that disease, should be kept under medical surveillance or observation until ascertained to be free of the infection. Such individuals, particularly if traveling by air, should be required to procure "Certificates of Origin" for the orientation of the health officers concerned. (d) Disinsectization of aircraft, vessels, automobiles, and so forth, coming from infected areas, may be required so as to prevent possible exportation of infected yellow fever vectors. (e) The object of quarantine should be to prevent the introduction of yellow fever virus into uninfected but infectible areas with as little inconvenience as possible to commerce and travel. (f) The authorities of countries where yellow fever is present should keep public health agencies informed as to the occurrence and extension of the disease. Morbidity and mortality statistics should be promptly and accurately collected and reported. (g) Bills of health should state accurately yellow fever conditions existing on the date of issue. (h) Government authorities should faithfully enforce all provisions of international treaties and conventions relating to yellow fever.

Gerhardt's disease.—Erythromelalgia is known as Gerhardt's disease. It is named after Carl Adolph Christian Gerhardt, a German pediatrician (1833-1902), whose paper on the disease with which his name is linked was published in 1892.

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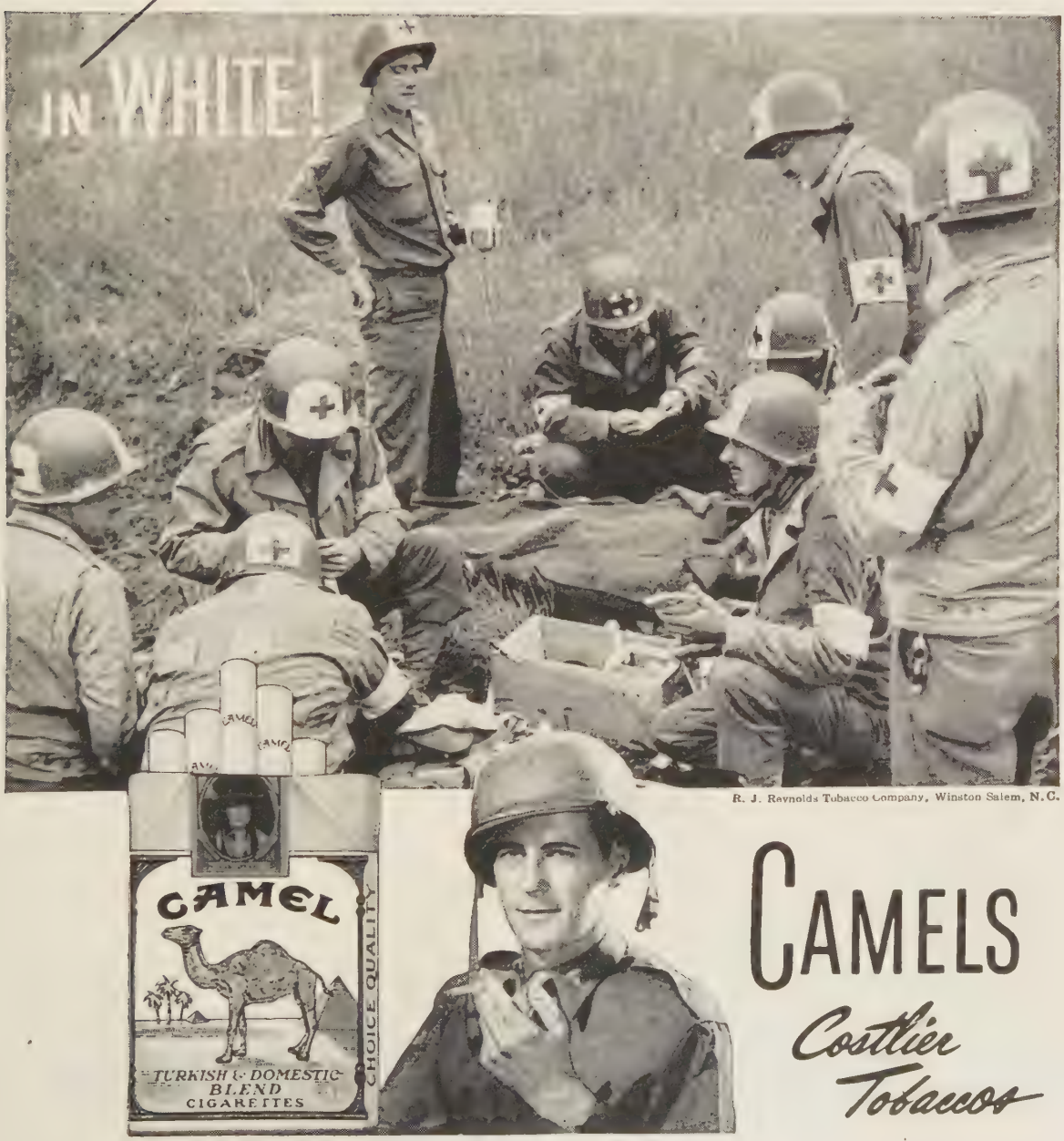

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Motives for Suicide

The motives for self-inflicted death frequently cannot be determined with accuracy, says the *Statistical Bulletin* of the Metropolitan Life Insurance Company. In many cases suicide notes or other sources of information tend to conceal rather than reveal the true reasons for the act. There are, however, some pertinent data available which provide an insight into the circumstances leading to suicide. It is well known, for example, that the suicide rate tends to vary inversely with the curve of business conditions, indicating that financial difficulties are frequently a motive for self-destruction. But in recent years jobs have been plentiful and well paid, and business has been good, with the result that the economic motive has been largely eliminated. Nevertheless, there are still about thirteen thousand suicides a year in the United States, and several times that number of persons who make an ineffectual attempt to die by their own hand.

In discussing the motives for suicide during a period when favorable economic conditions prevail, it is pointed out that there are marked differences according to sex. Among males, ill health ranks as the leading motive, accounting for nearly forty percent of all attempts at suicide, whether successful or not. About thirty percent of the attempts are attributed to domestic difficulties, and only four percent to love affairs. Among women, domestic troubles are given as the motivating cause in about half the attempts at suicide and love affairs contribute a little more than ten percent. Ill health ranks second in numerical importance, accounting for about one fifth of the cases. In each sex, general despondency and the death or illness of others are responsible for a number of suicides annually.

Of special interest is the relation between the motive for suicide and the frequency with which the attempt is successful. Among men, half the number of the attempts at suicide for reasons of health are successful, and among women the proportion is about one quarter. Domestic difficulties and love affairs show a much lower proportion of successes, particularly among women. Only fourteen percent of the attempts by men because of family worries are successful, and about ten percent of those motivated by love affairs. Among women, of the attempted suicides because of domestic difficulties, only two percent are successful, and of 114 attempts attributed to love affairs, only one succeeded.

The motives for suicide are so many and so varied that the problem obviously cannot be solved through any one method of approach. The responsibility for this task must lie with our social institutions, the mental hygiene movement, and the field of medicine.

Contact Lens Research.—At a meeting of the organization committee of the Society for the Advancement of Contact Lens Research, held in Chicago on March 17th, the Society was incorporated under the laws of the State of New York. A temporary board of directors was named, and forty-two members were admitted into the Society at this meeting. Because of war time restrictions imposed on travel, it was decided that the first annual meeting of the Society, scheduled to be held in Detroit in May, was postponed until travel restrictions were lifted.

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AMONG MY BOOKS—AGAIN

THE HONOURABLE WILLIAM RENWICK RIDDELL
Toronto, Canada

Some years ago, I asked the Academy of Medicine of Toronto to accept some of my books hoping they might be of use to some members of the profession; the Academy was gracious enough to receive my little gift.

Again, I find, on browsing around my library, a number of books, which conceivably may be of some little benefit to the Academy or some member of it; and again, I ask the Academy to accept them.

I again give some notes as to the authors, and, occasionally, a short statement of part of the contents.

Advice to the People in General With Regard to Their Health. Translated from the French edition of Dr. Tissot's *Avis au Peuple, etc.,* with several occasional notes, adapted to this English translation, by J. Kirkpatrick, M.D., London, MDCCLXV: 8 vol. Pp. 608, and table of contents, pp. 4.

This work, endorsed as *Tissot on Health,* is a somewhat free translation of the French publication, *Avis au Peuple, etc.* The author, Samuel August Andreas Tissot, was a Swiss from the Vaud Canton, for a considerable time professor in Paris, a friend of the better known Zimmermann, with whom he agreed on the *infarctus* doctrine of impacted faeces caused by thickening of the "humors" in the portal system and the intestines, which doctrine, it is said, developed a widespread clyster-fashion of visceral clysters three times a day. As Bass puts it (*History of Medicine,* Handerson's American edition, p. 623): "Lords and ladies vied with each other in belabouring their infarctus and in practising visceral clysterization". He paid great attention to hygiene and wrote extensively on the subject, this book, and that of which it is a translation, being devoted thereto. He was an advocate of hydropathy, which may be said to have originated in England with Dr. James Currie, the biographer of Robert Burns. His treatments are not always regular, but he favors the cupping-glass with scarification and bleeding twice or thrice of the neck in cases of quinsy; so, too, he warns against the vomit "before the humors have been diminished by bleeding", and says that "Purges sometimes occasion a general Inflammation of the Guts, which terminates in Death". If we exclude bleeding, they are much what a modern physician would adopt.

Practical Observations on Venereal Complaints. By R. Swediaur, M.D., the third edition corrected and enlarged, to which is added, *An Account of a New Venereal Disease,* which has lately appeared in Canada. Edinburgh, 1878.

Franx X. Swediaur (1748-1824) graduated at Vienna as M.D., in 1772; he practised in Vienna and later in London and Paris. He was a first-rate authority on syphilis and wrote extensively on the disease. His *Traité complet sur les Symptomes, la Nature et les Traitements des Maladies Syphilitiques* was translated into English by Thomas T. Newson of Philadelphia in 1815, having been published in Paris in 1798. It was long a leading textbook, but it may fairly be considered as superseded by the Bumstead of my student days—an admirable book but outworn. Ehrlich and Wassermann have revolutionized our conceptions of the treatment, as well as the diagnosis and prognosis of the *morbus gallicus.*

The symptoms, treatment and prognosis of the disease as then understood are fully treated of; some odd facts (?) are given, as, for example, that dogs are affected by the disease in Peru but not in North America. He thinks it quite wrong to imagine that the disease came from this Continent with Columbus on his first voyage, and notes that no mention is made by the earlier writers on the disease of the pudenda being affected by it, and the disease was then looked upon as a kind of plague, pests, *morbus pestilentialis,* and it was not till the beginning of the sixteenth century that it was considered to affect the pudenda. Having had a chancre, he cured himself in ten days by mercury pills. He does not agree with the celebrated Dr. John Hunter and indulges in a caustic review of his publication on the disease.

To us, the most interesting part of this work is the description of the work in Chapter XII in which he describes *Le Mal de la Baye de St. Paul,* then recently broken out in Canada; he thinks it identical with the Scottish *Sibbens* and doubts its identity with syphilis. A very full and exhaustive *Pharmacopoeia syphilitica* completes the treatise.

First Lines of the Practice of Physic. By William Cullen, M.D., professor of the practice of physic in the University of Edinburgh. Fourth edition. Edinburgh, M.DCC.LXXXIV. Four volumes. 8vo.

William Cullen was one of the best known physicians of his time (1710-1790). He was born in Lanarkshire, Scotland, educated at the Glasgow University, and after the custom of his times, became a pupil of a practitioner at Paisley. He then went to London and became a surgeon on a merchant ship; then to Edinburgh University, but graduating at Glasgow in 1740. He became professor of medicine at Glasgow University in 1751; professor of chemistry at Edinburgh University in 1755; professor of the practice of physic in 1773, and president of the College of Physicians there in 1773.

The present work was very popular; he opposed Boerhaave's eclectic system, and was one of the first to recognize the distinction between the classes of nerves. He is considered the real father of modern Solidism—the main foundation of his system being the solid parts of the body, not the fluids, the traditional "humors"; with him, the chief agents were the nerves. We find the terminology, "nervous force", "nervous activity", "nervous principle", constantly recurring in his writings—sometimes, indeed, he uses the expression, "animal force" or "energy of the brain".

His explanation of gout had great fame; he said that the disease, which was the despair of physicians, "the reproach of medicine", depended on atony of the stomach or organs of digestion. His recommendation of strengthening and stimulating remedies, such as wine, quinine, etc., is also notable; so, too, opium was a somewhat favourite medicine with him.

He has sometimes been credited with the sarcastic lines on his fellow practitioner, Dr. Lettsom, who, differing from most doctors, made a large fortune by his practice. They read:

> "When patients sick to me apply,
> I physics, bleeds and sweats 'em
> If after that, they choose to die,
> What's that to me?
> I. Lettsom."

(To be continued)

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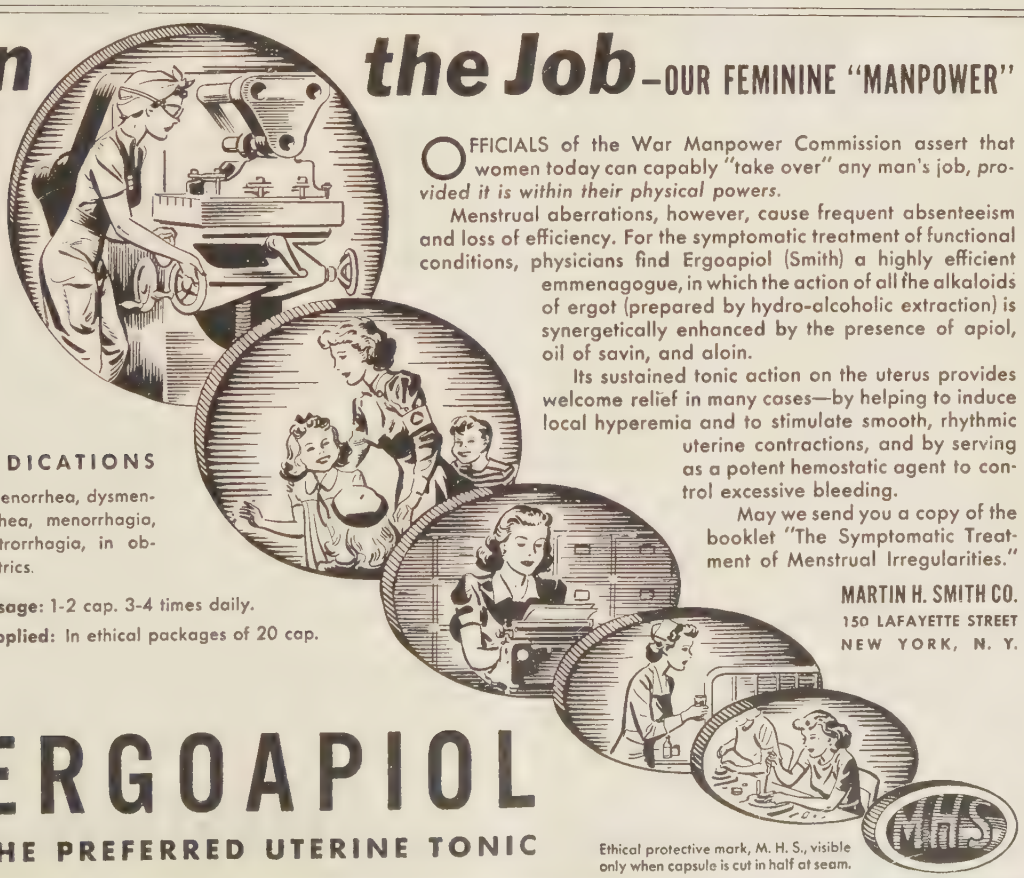

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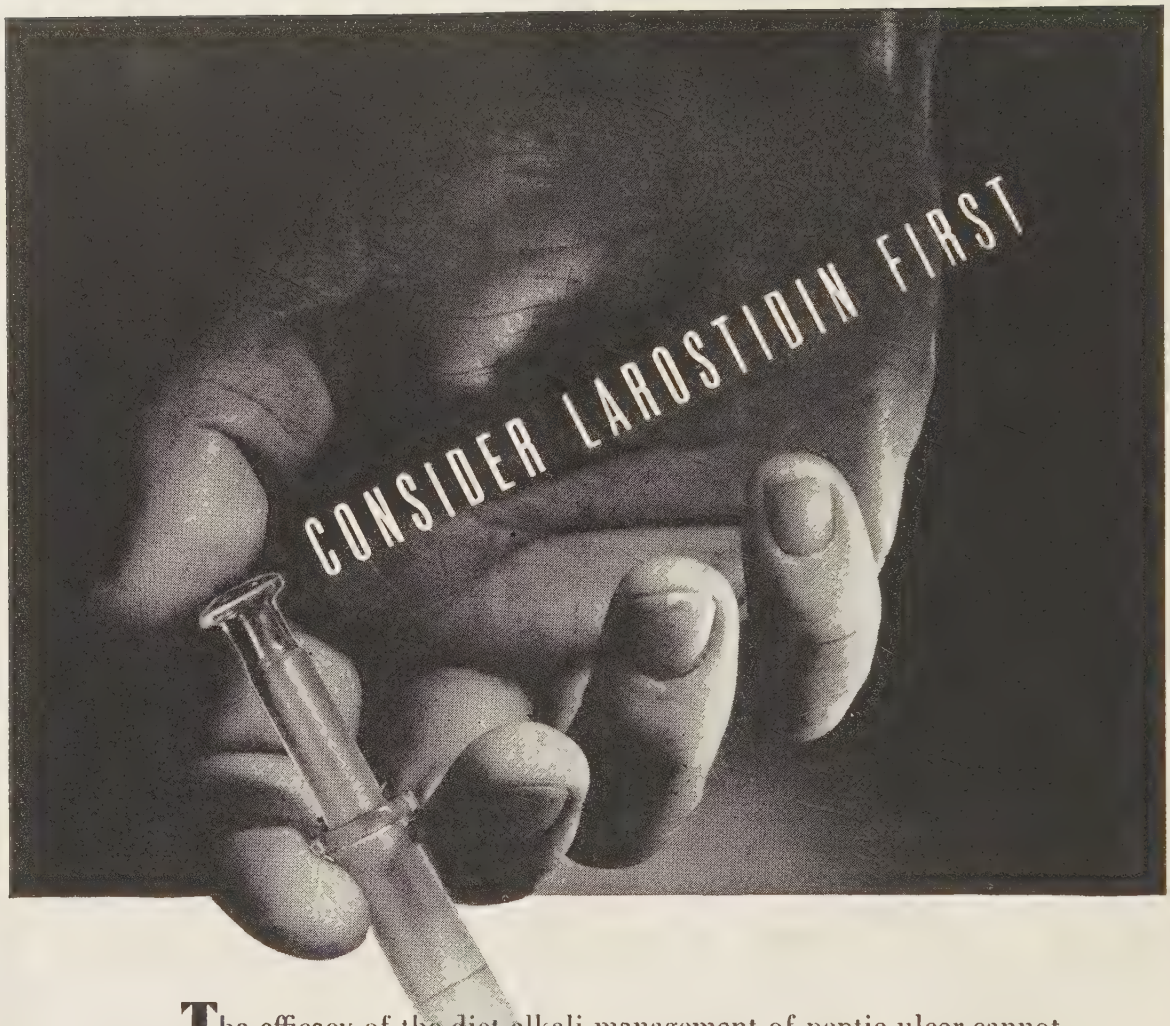

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VOL. 158, NO. 5 MAY 1945 WHOLE NO. 2748

PLASMACYTOMA WITH AMYLOIDOSIS*

Report of a Case with Postmortem Findings

NATHAN BLUMBERG, M.D. and MAX W. FISCHBACH, M.D.
Philadelphia, Pa.

Introduction

A case of plasmacytoma with amyloidosis is presented because of its rarity and because the protean features of this malignant disease are not sufficiently well known to permit of early diagnosis in most instances. The most prominent manifestation, whether it is anemia, arthritis, neuritis, or nephritis, often leads to a false diagnosis and a halt in the search for the myeloid neoplasia. Since 1850 when the disease was first described, six hundred and fifty-two cases have been recorded in the literature (1, 2, 4, 22, 24, 25). An interesting feature of this case is an associated amyloidosis, this being the forty-first instance in the literature of myeloma with amyloidosis.

Case Report

The patient, E. P., a man, fifty-three years old, Jewish, a tailor by occupation, was admitted to the medical service on February 21, 1944. His chief complaint was the insidious onset of malaise and dyspnea which had existed for the past six months and pains in the back, progressively severe, for the past three months. He complained bitterly of his inability to work because of difficulty in walking and bending. The back pain was not aggravated by coughing or straining. The last few weeks his pain had been constant, day and night, and had confined him to bed. There was no antecedent history of injury or accident and no previous illness. An x ray of the spine taken before patient was admitted to the service showed "arthritis."

There was no family history of cancer or tuberculosis, and the patient's past history was free from illness, with the exception of acute urethritis at the age of eighteen. He had continued to work until two months prior to admission to the hospital. The systemic review was entirely negative except for occasional epistaxis during the previous six months and nocturia two to three times a night within recent weeks.

Examination.—On admission, the patient was a pale white male who weighed 152 pounds. He appeared his stated age of fifty-three. The temperature (oral) was 99° F, pulse 88, respirations 22, and blood pressure in both arms 130 systolic and 70 diastolic. His face was lined with pain and he complained of constant backache and inability to make the slightest movement in bed without excruciating pain. When helped to his feet he walked with a stiff spine, on a wide base, and had to use a cane for support. The lumbar curve was obliterated, the paravertebral muscles were spastic, and he could flex only the cervical and upper dorsal spine. On getting into bed again, the movements of the entire musculoskeletal system were guarded and the back moved as one stiff mass.

The skin, mucous membranes, and nail beds were pale; there were no petechia, discolorations, or trophic changes. There was no lymphadenopathy. Early Heberden nodes were noted, and the fingernails were spoon shaped. There was patchy diffuse tenderness over the entire dorsal, lumbar and sacral spine, especially in the region of the twelfth dorsal, and marked tenderness over both sacroiliac joints and the iliac bones. There was also marked tenderness to percussion in both costovertebral angles with diffuse tenderness over the entire costal cage, particularly over the lower ribs and at the costochondral junctions which gave the impression of a prominent "rosary". The pupils were round and equal and reacted to light and accommodation. Fundoscopy showed normal physiological cupping of the optic discs, no arteriolar or venule abnormality, no exudate or hemorrhage. The tongue showed no atrophy of the papillae; there was considerable pyorrhea and gingivitis. The thyroid was palpable but not enlarged or nodular.

The cardiac rhythm was regular, there was no demonstrable enlargement, and no murmurs were heard. Examination of the lungs revealed some dullness at the right apex posteriorly and limited but equal respiratory excursions. The liver and spleen were not palpable and no masses or other abnormalities were noted in the examination of the abdomen. The genitalia were normal except for some thickening of the left epididymus. Rectal examination revealed poor anal sphincter tone, a moderately enlarged and boggy prostate, free from nodules of stony hardness. Neuropsychiatric examination showed good orientation and insite. The cranial nerves, the deep and superficial reflexes and the proprioceptive and cerebellar tests were all normal.

Ancillary findings.—The urine was acid to litmus; specific gravity ranged between 1.007 and 1.024. The centrifuged sediment showed three to eight erythrocytes per high power field, many hyaline and occasional

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granular casts. The hemogram revealed 9.1 grams hemoglobin per 100 c.c. of blood, erythrocyte count of 3,700,000 per cubic millimeter of blood, and leukocyte count of 8,500 per cubic millimeter of blood, with 76 percent polymorphonuclear neutrophiles, 2 percent eosinopholic neutrophiles, and 22 percent small lymphocytes. No abnormality in the erythrocytes or leucocytes were noted in a study of seven hemograms over a period of five weeks. A reticulocytosis of 2.9 percent was found in the first hemogram but the reticulocytosis subsequently fell to 0.3 percent and later none were found in a survey of high power fields sufficient to count 300 leucocytes. The thrombocytes were normal on two occasions, numbering 305,600 and 165,000 per cubic millimeter of blood respectively. The bleeding time (ear lobe method) was one minute; the coagulation time (capillary tube method) was three and one-half minutes. Fresh drawn blood placed in a test tube coagulated with a firm clot which showed good retraction. The fasting blood sugar was 110 mgs. percent; the blood urea nitrogen was 16.5 mgs. percent; the serum calcium was 11.65 mgs. percent, serum phosphorus 5.50 mgs. percent; the blood phosphatase 2.17 Bodansky units.

The stool examination was four plus for occult blood using the benzidine reagent. The sedimentation rate by the Cutler tube method showed a thirty-two mm. drop of erythrocytes in the first ten minutes. Radiographic examinations showed demineralization of the entire dorsal, lumbar and sacral spine, as well as the bony pelvis. The radiologist reported a marked spondylarthritis of the lumbar column, a fifty percent compression fracture of the twelfth dorsal vertebra with widening of the twelfth intravertebral space, and bilateral osteoarthritis of the sacroiliac joints. X ray of the chest revealed normal lung fields and normal cardiac contour. The ribs and sternum were not unusual. X ray of the esophagus, stomach, duodenum, and colon revealed a normal gastrointesinal tract. The long bones and skull appeared normal in the x ray films.

Course in the hospital.—The foregoing rather extensive survey yielded no single diagnostic clue. The radiologist, upon whom we often rely unduly hoping for pathognomonic radiographic findings, could only suggest metastatic carcinoma to the twelfth dorsal vertebra, skeletal demineralization of disuse, and hypertrophic arthritis.

At this time a reappraisal of the facts at hand revealed the following:

1. Weakness, dyspnea, and backache of less than a year's duration, becoming progressively severe, in a man aged fifty-three.

2. Marked tenderness of spine, ribs, sternum and iliac bones.

3. Temperature range between 98°F. and 100°F., and a blood pressure range of 110-130 systolic and 60-80 diastolic.

4. Erythrocytes and casts in the urinary sediment and positive occult blood in the stool.

5. Hypochromic anemia, normal leukocyte count, markedly rapid erythrocyte sedimentation rate, and fair evidence of erythropoietic activity. (Table I.)

6. Demineralization of the flat bones with the exception of the skull, and spontaneous fracture of the twelfth dorsal vertebra.

These findings suggested the diagnosis of myelomatosis. Confirmatory cytological and chemical studies were done on the body tissues. The serum proteins showed hyperproteinemia with a reversal of the albumin ratio. (Table II.)

Table I.

Date	Hemoglobin	R.B.C.	W.B.C.	C.I.
Feb. 22	9.1 grams	3.700,000	8.500	.7
Feb. 29	8.4 "	3.290,000	7.250	.7
Mar. 10	8.7 "	3.460,000	8.700	.7
Mar. 21	6.9 "	2.720,000	6.650	.7
Mar. 27	6.7 "	2.770,000	4.800	.7

Table II.

Date	Total Serum Proteins	Albumin Fraction	Globulin Fraction	AG. Ratio
Mar. 3	9.0 gms. %	3.06 gms. %	5.94 gms. %	.52
Mar. 13	11.64 gms. %	3.70 gms. %	7.94 gms. %	.47

Bence-Jones proteinuria and proteinemia was looked for but could not be demonstrated. The blood smear showed excessive rouleaux formation and a drop of fresh blood sealed under a cover slip on a warm stage revealed the presence of autohemoagglutination. The phenolsulphonphthalein urinary excretion test showed fifteen percent of the dye excreted in the first hour and twenty-two percent in two hours. The Congo red test, using five cc. of one percent aqueous solution of Congo red intravenously, showed ninety-five percent of dye absorption in one hour. The van den Bergh test for serum bilirubin yielded .25 mgs. percent indirect reaction. The blood cholesterol was 290 mgs. percent with sixty-eight percent cholesterol esters. The urine was free from bile or excessive urobilinogen. The bromsulfalein test for hepatic function showed zero percent dye retention in thirty minutes, using two mgs. of dye per kilo of body weight.

Under local anesthesia, biopsy of a rib was performed. The histological section showed the presence of a great many plasma cells with eccentric nuclei in the marrow and clusters of plasma cells infiltrated into the bone tissue. Five weeks after admission bilateral hypostatic bronchopneumonia developed and the patient died one week later.

Autopsy report.—1. Plasmacytoma at third and fourth right and third left costochondral junctions.

2. Plasma cell infiltration of cortex of vertebral bodies making them a mere shell of bone. The right ilium likewise was almost paper thin having no medullary cavity whatsoever.

3. There was abundant red marrow in the sternum, ribs, and vertebræ.

4. Bronchopneumonia of lower lobes bilaterally. In the right upper lobe there was an orange-sized mass of firm pale grayish green tissue extending from the hilus out toward the periphery and at its peripheral margin it was well demarkated. This tissue was a plasmacytoma of the lung (radioluscent).

5. The kidneys did not show extensive plugging of the tubules with casts, but there was cloudy swelling and amyloidosis.

6. There were plasma cell metastasis to the liver and tumor emboli in the hepatic veins. There were also patches of hepatic amyloidosis and an interstitial hepatitis.

7. The spleen showed acute splenitis and amydoidosis.

8. A mesenteric lymph node showed plasma cell metastasis.

Discussion

In 1848 Bence-Jones first published his classical observation on a "new substance occurring in the urine of a patient with mollities ossium". The urine was from a man who on postmortem examination was found to have tumors of the ribs and vertebræ. The case was described in 1850 by Macintyre (3) who regarded it as a case of osteomalacia. However, it is the first case report of what was later to be known as multiple myeloma.

The protein first described by Bence-Jones has since been called Bence-Jones protein. Meyler (5) suggests that Bence-Jones protein is found in normal bone marrow and is probably part of the lymphocytes and other leukocytes. Bence-Jones proteinuria has been found in endothelioma, sarcoma of bone, carcinoma of bone, metastatic tumor of bone, senile osteoporosis, caries of the spine, polycythemia, chlorosis, and leukemia, both lymphatic and myeloid types (1, 5, 6).

Geschicter and Copeland (8) in a review of 425 cases from the literature found a recorded incidence of sixty-five percent Bence-Jones proteinuria in multiple myeloma.

Bence-Jones bodies may not be found in isolated specimens of urine and it is suggested that (7) tests for Bence-Jones proteinuria be done repeatedly on specimens from twenty-four hour collections.

The presence of renal insufficiency has been noted often in the literature (27), in fact, the presence of renal insufficiency with normal blood pressure has frequently directed the clinician's attention toward multiple myeloma. Bell (20) has shown that the direct action of myelomatosis on the kidney tissue is the production of casts of Bence-Jones protein in the renal tubules.

Hyperproteinemia.—Ellinger (11) in 1899 showed the presence in the blood serum of a protein which was precipitated on heating to 56°C. Magnus-Levy (15) in 1933 collected thirty-one published cases of multiple myeloma with reports of blood proteins, eighteen gave values over eight grams percent, and three of his own cases had values over nine grams percent. Magnus-Levy believes the hyperproteinemia is due to an increase of the globulin fraction of the blood serum in the highly unstable forms of euglobulin.

Gros (10) found pseudoglobulins one and two are the chief globulins in his case of myeloma.

Cantarow (9) in 1935 demonstrated Bence-Jones proteinemia in a case of multiple myeloma. The serum was heated in a water bath and precipitation was noted to begin at 52°C., increased to 65°C., and began to diminish at 85°C. The precipitate increased again on cooling to 65° and disappeared at 10°C. The Bence-Jones protein fraction was found to be three grams percent when the total serum proteins was 8.7 grams percent; and 5.2 grams percent when the total serum proteins were 11.3 grams percent.

Wintrobe and Buell (12) make further observation on the hyperproteinemia of myeloma. The hyperproteinemia imparts to the formed elements of the peripheral blood the property of rapid sedimentation and autohemagglutination. H. A. Reiman (13) reported a case in which he was led to the diagnosis of myeloma by the observation of excessive rouleaux formation and autohemagglutination. Foord (14) ingeniously was able to visualize intravascular clumping of erythrocytes by ophthalmoscopic visualization of the retinal vessels after slowing the stream in these vessels by means of pressures over the eyeball.

The hyperproteinemia imparts to the erythrocytes the property of excessive rouleaux formation (16), which in turn leads to rapid sedimentation of the erythrocytes, autohemagglutination, and spontaneous vascular thrombosis.

The hyperproteinemia seems to predispose also to a hypercalcemia probably due to an increase in the protein bound calcium of the blood serum (17). The hypercalcemia, though never very great, joined with the radiographic finding of bone demineralization, occasionally leads the clinician to an erroneous diagnosis of parathryoid hyperactivity. The differential diagnosis of myeloma, Paget's disease, von Recklinghausen's disease, and neoplastic disease of bone, from the biochemical point of view, is reviewed by Gutman, Tyson and Gutman (26).

In their review of myeloma, Robbins and Kydd (18) noted only twenty-three cases of hypercalcemia. In fourteen of these a hyperproteinemia was found, in four there was hypoproteinemia, and in five the proteins were normal.

Tumor.—In the recent literature it is becoming increasingly more common to note the specific type cells or combination of cell types which are present in the myeloma, whether it is the solitary, multiple, or diffusely infiltrating type involving the marrow rather uniformly and therefore giving the radiographic picture of demineralization rather than single or multiple punched out areas in the flat or long bones.

The neoplasm is a growth springing up from the reticulum cells of the osseus medulla, giving rise to a solitary, multiple, or diffusely infiltrative destructive lesion of the compact and spongy tissue of the bony substance.

The plasma cell is round or oval, from nine to eleven microns in diameter. It has an eccentric nucleolus and central vacuole. It has a basophilic cytoplasm and the nuclear chromatin is arranged in clumps like the spokes of a wheel.

The bone marrow neoplasia precipitates the profound anemia which is frequently characterized by a color index of unity. The differential diagnosis of this type of anemia should include myelomatosis as well as the usual Addison-Biermer anemia, pellagra, nontropical sprue, celiac disease, idiopathic steatorrhea, and cirrhosis of the liver.

Likewise, a thrombocytopenia is occasionally encountered in myelomatosis, presumably due to crowding out of the megakaryocytes of the bone marrow. This gives rise to a bleeding tendency, the poor clot retraction, and prolonged bleeding time.

The neoplastic invasion of the bony structure gives rise to pain, insidious in onset but unremitting after extensive involvement. Spontaneous fracture of thin and brittle bones gives rise to excruciating pain, in fact the multiple bone pain and tenderness should always direct the clinician to possible diagnosis of myelomatosis.

Single or multiple punched out areas in the x rays of the bones lead to a presumptive diagnosis of myeloma by the radiologists. Generalized demineraliza-

tion noted by x ray is inconclusive and must be differentiated from senile osteoporosis, osteoporosis of disuse, parathyroid adenoma, and myelomatosis by further study.

A transverse myelitis not infrequently intervenes as a complication of myelomatosis of one of the spinal vertebræ (21, 25), giving rise to paraplegia and bladder dysfunction.

Coexistence of amyloid disease.—The coexistence of amyloid disease with myelomatosis has been stressed by Magnus-Levy (15), and Atkinson (1) has collected forty cases from the literature up to date of his report in 1937. This case appears to be the only one to be reported since 1937.

Summary

A case of plasmacytoma with amyloidosis in a white man, aged fifty-three, is presented. The diagnosis was suggested purely on clinical grounds and then confirmed by chemical, cytological and postmortem findings. The metastatic plasmacytoma of the lung was not found by x ray of the lungs. Bence-Jones proteinemia and proteinuria and punched out areas in the x rays of the bones were conspicuous by their absence. This case is the forty-first to be reported of plasmacytoma associated with amyloidosis.

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THE ROLE OF DIABETIC NEUROPATHY IN THE ETIOLOGY OF GANGRENE*

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Diminished sensation in the feet and toes of diabetic patients is a common occurrence. This phenomenon is inadequately appreciated by patients and physicians. All too frequently a diabetic, even with good peripheral circulation, develops local gangrene from shoes which caused no discomfort, but which were too tight, or blisters on the toes for no known reason, or burns from a hot water bag which didn't feel hot.

While such injury has been ascribed to pre-existing arterial occlusive disease, there is accumulating evidence that it is not infrequently due to a hypesthesia initiated by diabetic neuropathy. This hypesthesia is not related to the degree of peripheral arterial sclerosis while the severity and the extent of the gangrene may be.

Local pain in diabetes may be due to ischemia in cases of impending *spontaneous gangrene*; or to neuritis independent of an accompanying peripheral sclerosis. In the latter the pain subsides only after treatment of the neuritis.

Recently we have encountered several instances in which the hypesthesia in the feet to diabetic neuropathy was so pronounced that surgery could and was performed without the use of administered anesthesia. The following case is reported as an example in which neuropathy could have been easily overlooked because there were no subjective neurological symptoms.

Case Report

D. F., Beth Israel Hospital Case No. 64549. The patient, a man aged sixty-one years, was first seen on May 18, 1942, because of an infection in the right little toe and adjacent portion of the foot. Ten days previously he first noticed painless swelling and redness

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of his toe as a result of pressure caused by poorly fitting new shoes. He applied various preparations but nevertheless the infection spread. The patient stated that he had diabetes mellitus for seven years, that he rarely followed his diet and never took insulin. His urine usually showed sugar. He lost about twenty pounds of weight in five years. He never suffered from cold feet or had any paresthesias. He had been suffering from arthritis for many years. At the age of forty-four he had an episode of swelling of the joints of the ankles and knees, not associated with fever, redness or heat.

On physical examination the heart showed signs of a mitral stenosis and aortic insufficiency. Corrigan pulse and capillary pulsations were present. The dorsum of the right fifth toe and the adjacent portion of the foot showed sepsis, sloughing and gangrene; there was contiguous cellulitis and lymphangitis. The dorsalis pedis pulse was easily palpated and the foot was warm. Fluctuation was noted between the extensor tendon and the overlying sloughing skin. Thus, immediate drainage was indicated.

The neurological findings were as follows: There was diminished sensation to pin-prick, also absence of sensation to heat and cold, and vibratory sense in both legs up to the thighs. The right knee jerk was slugged and the left could hardly be obtained. The ankle jerks were absent.

On probing the foot, it was observed that the patient had a marked deep hypesthesia. The incision and drainage was done, therefore, by scissors without the use of anesthetic with no discomfort or pain to the patient. The pus had burrowed completely around the middle phalanx.

Surgical Procedure

A few days later, when the cellulitis and lymphangitis had subsided, the bone was painlessly removed because of osteomyelitis. Several days later we decided that an amputation of the fifth toe, through the proximal phalanx could shorten the patient's convalescence. This was done in the operating room where a general anesthetic could have been given if found necessary. A racquet incision was made with the handle extending over the metatarsophalangeal joint. The flexor sheath and tendon were transected and protected by gauze until the amputation through the proximal phalanx was completed. The wound was sprayed with sulfanilamide powder and packed with vaseline gauze. This time again the patient felt no discomfort or pain, although no anesthetic was used. It is interesting that at the time of the toe amputation, a small papilloma of the left buttock was snipped off with scissors. This procedure, he complained, was painful. The toe amputation wound healed completely in two weeks. The serology was found negative. The spinal fluid showed a total protein of ninety-three mg. and a negative Hinton and gold sol. The diabetes was easily controlled by a diet of carbohydrates, 140; proteins, 80; fats, 100, with ten units of protamine zinc insulin.

Comment

This case illustrates the fact that neuropathy can be present in a diabetic patient without subjective neurological symptoms. A pronounced hypesthesia, due to the neuropathy, can result in trauma with serious consequences. It must be assumed that the trauma to the toe by the shoe was a result of the diminished sensation. That diabetic neuropathy is due to a vitamin deficiency and that deficiency manifestations are common in diabetes mellitus has been previously stressed by Rudy (1, 2, 3, 4, 5).

It is generally accepted that diabetic patients with peripheral sclerosis are suffering from hypesthesia in the feet and are, therefore, subject to injuries which may have tragic consequences and may lead to amputation of a leg. But it is not as well known that hypesthesia may be due to an associated neuritis or to a neuritis in the absence of peripheral sclerosis. In such a case, even in the presence of intermittent claudication, there may be a good pulsation in the dorsalis pedis and tibialis posterior arteries. The intermittent claudication is then probably due to the impaired nutrition in the muscles which has been brought about by the disturbance in the carbohydrate metabolism as a result of a thiamine chloride deficiency.

McKittrick (6) states that the painful foot in the diabetic patient is the foot with a poor circulation and poor prognosis, while the hypesthesia foot is often the one with a good circulation. Root (7) in discussing the frequency of impaired sensation in diabetic neuritis states that the lack of sensation is best shown in cases with surgical conditions in whom incision and drainage can be done without anesthesia. Jordan (8) reported two cases of infection of the feet in diabetic patients with hypesthesia due to diabetic neuropathy. The pulsation of the dorsalis pedis could be detected in one and not in the other. In both the infection responded well to conservative treatment. The diabetes was fairly well controlled by a varied diet, supplemented by Brewer's yeast tablets and insulin. One patient showed no improvement in the neurological signs, while the other showed in four months a definite return of sensation and position sense.

Gangrene in a diabetic foot may be the result of one of the following causes, separately or combined; peripheral sclerosis, peripheral neuritis and a pellagrous tissue vulnerability. In the first case the dorsalis pedis pulsations are absent, while in the other cases the pulsations in the dorsalis pedis are palpable. In the case described here the gangrene was precipitated by the unsuspected hypesthesia caused by a diabetic neuropathy. Blisters on the foot of a diabetic patient due to pellagra have been described by one of us (A.R.) (1).

Conclusions

Diabetic neuropathy frequently manifests itself by hypesthesia in the feet. Gangrene may follow as a result of trauma of which the patient may be unaware. The hypesthesia in diabetic patients is unrelated to the degree of peripheral sclerosis. An illustrative case is presented.

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311 COMMONWEALTH AVENUE

ACQUIRED FACIAL RESEMBLANCE

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Some years ago, during the course of a general practice, I observed that in some of the families with which I came in contact, a definite facial resemblance appeared between husband and wife after a somewhat lengthy period of married life. The frequent occurrence of this phenomenon led me to believe it to be an established fact.

At first, I noted that the facial characteristics of the married couple appeared to be that of brother and sister, cousins, or some other family relationship. I became interested and decided to make a survey of the subject, as I had plenty of time. My inquiries resulted in the exclusion of any ancestral derivation of the phenomenon and established the fact of an actually obtained facial resemblance in married couples.

This outward resemblance of husband and wife presented a real similarity in the appearance of the two faces, with a complete likeness. It was not caused by the loss of masculinity in the man or of femininity in the woman. Neither was it a manifestation of the presence or approach of senility, which often changes the natural deposits of adipose tissue in women, making them more muscular, or more hirsute, or changing the color of the hair in both men and women. It was the established fact, that at any age, the husband and wife became singularly alike in the expression of their faces, involving forehead, eyes, nose, mouth and coloration of the skin, which became the same in both. The countenances assumed the same shape, presenting a similar roundness or an equally elongated outline. The eyes in both were identically sunken, or uniformly prominent below proportionate foreheads, with the same expression. The mouths were characteristically the same in size, both when open and closed; and there was an evenness of the interspaces between the two lips when talking. The teeth were equally seen or covered by the lips during laughing, smiling, and expressing sensations of happiness or surprise. It may be added that in some cases there was a development of only one similar feature of the two faces, creating what one occasionally heard as the "almost resembling" of such parents. Another point of interest was the fact that there was no positive assurance of whether it was the husband or the wife who contributed most to the development of the resemblance.

The lack of definite etiological factors, with the scientific presentation of exact statistics and figured out percentages, and illustrations of such cases, does not make the above mentioned truth fortuitous. Real observation alone makes it almost axiomatic, and from my personal observations, though not inclined to empiricism, certain features and facts may be enumerated. There was no clear-cut anatomical alteration, but there appeared a functional imitation of personal features. A physiognomy developed with the mutual configuration of the faces. The age of the couple seemed of no importance, but the number of years of married life was in direct proportion to the appearance of the resemblance, though it might be acquired within two to three years of consecutive wedded life. It occurred in couples of all complexions, but was more frequent in those where both were blond. They seemed to be more susceptible. It may aiso be remarked that this acquired resemblance was conspicuous in negroid couples.

It is my opinion that the acquired likeness is encountered in about fifteen percent of the average inhabited localities. There is no intention of contradicting the old saying of "likes repel, unlikes attract", which is still almost a dictum of psychological principles. Neither is there an aim to solve the problem of how much maleness and how much femaleness in each is necessary to induce a proper development of the resemblance, nor is there enough material to explain the disappearance of the likeness in cases where husband and wife have been separated for a time, from whatever cause.

It is occasionally heard: "This couple is like a brother and sister", expressing the similarity in the appearance of a husband and wife, without noting the fact that it is a newly developed feature. Similarly, it may be found that a child resembles both father and mother, overlooking the fact that the father and mother also resemble each other.

Psyche and soma, previously formulated as mind and body, bring to view the observation presented herewith, associated with the impulsive correlation at large. In the human body the soma becomes the substance of the psyche, in multiple and innumerable faculties. In a wedded life, with the progress of time, love and harmony, so frequently in evidence, may affect the facial nerve-endings, with perhaps some other cranial branches, to a point of a frequent subconscious imitation, and thus develop similar expressions and features of their faces. This process is a modification of some physiological traits of the soma by the psyche.

Summary

That husband and wife often acquire a facial resemblance after several years of married life is presented as an established fact, which cannot be fully explained until more information regarding the phenomenon becomes available Psychosomatic aptitudes create the capacity for such seemingly plastic adjustments.

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Symposium on Neuropsychiatry

THE PROBLEM OF OVERAGED BACHELORS

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The type of individual to be discussed is known to everyone—the man[1] in his early forties or fifties who has never married. No one believes the elderly bachelor's rationalizations, such as, for instance, lack of opportunity, time, money, and what not. Even the psychologically untrained observer calls him "queer", which is a popular synonym for "neurotic".

Freudian psychoanalysis has until now paid very little attention to the "forgotten man" of this type, with the exception of one large group, made up of the hysterical bachelors, who are unconsciously fixated on the Oedipus complex level. For the hysterical bachelor, mother and prospective wife are unconsciously one and the same, and marriage is therefore to be avoided. The sex life of such a man is concentrated on prostitutes or easy girl friends, for which he can make use of the inner alibi, "Mother was an honorable woman; this harlot has nothing in common with her." Using this unconscious device, he can also, to some extent, depreciate the idealized mother unconsciously (Freud). The practical result of his fixation is that his potency is preserved with women of the harlot type but does not work with respectable women. The neurotic, "born" bachelor lives in this neurotic compromise. Sometimes his compromise is not so extensive, and he is a lifelong masturbator[2].

The man of this type often lives with his mother, who treats him as a baby. Looking at this relationship with the analytical microscope, one soon discovers that not only repressed libidinous tendencies but also aggressive ones are involved. Such a man stays with his mother also as a defence against his inward aggression toward her, proving to himself unconsciously by staying with her that she is still unharmed by his unconscious aggression.

The problem arises as to what happens to these hysterical bachelors when they allow themselves to be pressed into marriage or even become engaged. Here are a few clinical examples:

A man of forty-five had been married for two years without having been able to deflower his wife. At her slightest approach toward him in bed, his erection collapsed. Nor had he ever had intercourse before his marriage. He had married because after the death of his mother, who was with him until he was over forty-two, he had felt lonely. Financial motives were also involved in his choice of his wife. She had some money, which she intended to put in his possession only after their marriage. Since he proved impotent, she did not give him the money after all, saying, "You cannot deliver, therefore I shan't deliver either." Analysis showed that he was unconsciously strongly fixated upon his mother, whom he had unconsciously loved and forbidden himself in the oedipal period. His reason for wanting to be made potent was interesting: It was simply that his wife would not sign over her dowry to him otherwise. His inability to have intercourse in spite of her ironic condition and her personal acceptability caused him, although he rejected analysis as "fantastic", to confess once "There may be something like an unconscious." Among other resistances, he adduced a religious one. He had overheard a conversation between his wife and her father hinting that she was an illegitimate child; she was therefore "impossible" to him. The argument by means of which he finally terminated analysis and rid himself of his wife was that he was having financial difficulties and would have to wait for a rise in prices. These difficulties were unconsciously ingeniously self-concocted. His wife had compromised to some extent over the matter of the dowry, allowing him to invest her funds. He did so at a time when the currency was unstable (The analysis took place in Austria in the early thirties). The investment was irrational and unsuccessful, but by means of it he diminished the foundation of his conscious wish for marriage —the dowry—and, at the same time, gratified his unconscious need for punishment and revenged himself upon the woman.

A member of a large concern had become engaged, at the age of thirty-five, at the wish of his mother and with great reluctance on his part, to a wealthy girl. He lived with his mother as a mother's boy, was potent with his "girl friends", and led a "merry bachelor's life", as he called the period before his engagement. On the day his engagement was announced, however, a veritable pandemonium of symptoms set in. All of his organs rebelled. He suddenly suffered from headaches, palpitation of the heart, diarrhea, urinary disturbances, profuse sweating, feelings of anguish and depression, disturbances of concentration, inability to work, and complete failure of potency. After some sessions in analysis the treatment was interrupted because of my vacation. When the patient returned in the fall, he presented himself as "cured". He had taken a "cold water cure" in a sanitarium and was enthusiastic about the result. He had, of course, also broken his engagement and resumed his happy former life. Naively, he *was not* aware that the latter circumstances had effected his "cure". The main portion of his analysis showed his strong libidinous attachment to his mother.

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[1]The spinster and the "garçonne" type will not be considered in this paper, which deals exclusively with the male bachelor. The psychology of the female bachelor is discussed in Hitschmann-Bergler's monograph, *Frigidity in Women*, Nervous and Mental Disease Monographs, No. 60, New York, 1936.

[2]Excluded from our investigation are all perverts, who don't marry because of their perversion, for instance, homosexuals. See the present writer's paper, "Eight prerequisites for psychoanalytic treatment of homosexuality", *Psychoan. Rev.*, 1944, 3.

He divided women into two groups—the respected images of her, who were sexually unapproachable (for instance, his prospective wife), and degraded women, with whom he was potent (Freud's "cleavage between sensual and tender components"). He confessed that his "breakdown" was the fourth he had experienced, "strangely enough", every time he became engaged! He decided to remain a bachelor, since marriage was "too much" for him.

A similar case was that of a patient thirty-eight years of age, who suffered from a "heart neurosis", which, he stated, had suddenly become so acute that he could not work "or even live". This man, too, lived with his mother. He was having an affair with a girl who worked in his office. Just before aggravation of his heart complaints, this girl had tried to force him to marry her. To a great extent he was uninterested in women, regarding intercourse as a disagreeable tribute demanded by "crazy women". He was interested only in the problem of motoring. Analysis revealed that his heart disease was chiefly the result of identification with his father's fatal illness, heart failure. His hysterical symptom was brought about by an unconscious feeling of guilt because of aggressive wishes toward his father and the masochistic elaboration of this boomeranging aggression, complicated by the unconscious pleasure of being overwhelmed. His feminine identification also contributed to this sexualization of aggression directed against himself. In addition to his heart symptoms, disturbances of potency appeared. He was no longer capable of carrying out his former entirely pleasureless sort of intercourse, and feared to die while performing the sexual act. That his hysterical heart complaints grew worse at the approach of marriage was due to his unconscious identification of his fiancee with his mother. When analysis was beginning to disclose his attachment to his mother, he reacted with the typical resistance, which for him took the form of temporary aggravation of his heart complaints and breaking off his engagement. He then decided that his heart was "too weak" for both analysis and marriage.

What grotesque consequences such unsolved mother fixations with a consequent desire for punishment may have, is shown also in the following case. An elderly business man came to consult me with his younger brother, who had just married. It appeared that after the wedding night, during which he had not even touched his wife, the groom had fled back to his mother and could not be prevailed upon to return to his wife. Though the marriage was a relief to his family and "financially profitable", the man "would not see reason", as his brother complained indignantly. He was deaf to threat and logic. He stated that he was not afraid of his wife, as his brother stated, nor was she unsympathetic toward him. He simply feared for his health, and had returned to his mother in order to consult his physician, who lived nearby. He clung to such a transparent rationalization in spite of his brother's scoffings. The psychoanalytical treatment desired for him by his brother could not be arranged because the father-in-law, who was to pay the expenses, preferred to give up his son-in-law.

Sometimes the results are less grotesque and more tragic. We read repeatedly in the newspapers of men, who, on the day before their marriage, commit suicide. The reports stress the fact that the reasons are incomprehensible, since the man had no financial worries and was "happily engaged". These cases escape even analysis; one can only suspect that motivations similar to those described in the four previous examples are involved, especially since some of the patients described before admitted that in the height of their conflict they "seriously considered suicide", and two of them very nearly carried it out.

A more crucial consideration than these patients who "escape marriage" and thus preserve their precious neurotic balance is that of patients who do finally marry. Why do they do so? What is the driving power behind their "desperate decision", to quote one such patient.

We have no reason to underestimate the driving power of the inner reproach, "a normal man marries". Many of these old bachelors build up a whole philosophy of the worthlessness of marriage, affirming that it is "antiquated", "silly", and "barbaric". They quote or plagiarize freely misanthropes à la Schopenhauer. Still, the driving power behind marriage is strong and inescapable—at least as a reproach of the inner conscience—for the cultural being. Even the institution of monogamy, so often ridiculed, has a powerful advocate in the unconscious conscience, even in men who openly proclaim polygamy as the normal state of affairs. The simple fact remains that in the cultural family there is *one* father and *one* mother, and they are married. Since every child identifies in the oedipal period with the parent of the same sex, the cornerstones for the conception of marriage and monogamy are acquired, strange as it may sound, in the nursery.

Since these driving forces are present even in the early part of life, they cannot account for the late decision of the old bachelor to marry. The simple but decisive fact is that *every neurosis increases with age*. In other words, the reason that some elderly men finally decide to marry *is explainable from the viewpoint of bowing at last not to normality*, as naive observers believe, *but quite the contrary, to neurosis*. They misuse marriage to repeat fully their childhood fixation, executing their neurotic repetition repertoire on the marital stage. Two clinical examples will bear this out.

Case Histories

CASE I.—Mr. A. consulted me because of marital difficulties. He was a goodlooking man of forty-three, with the charm and cynicism of a gamin. He explained his constant conflicts with his wife very simply: He was a "born bachelor", who did not marry, but was married by his wife. He had warned her but she had insisted, "and what can you do against a woman's determination"? Of women in general he spoke disparagingly. They were inferior creatures with no brain except for intrigue. I asked him of what his conflicts with his wife consisted. "Oh, she is terrible; she behaves like a governess, makes constant rows, is hysterical and overbearing." "How long did you know your wife before marrying her"? I wanted to know. "A year or so. But never mind, she changed completely. She told me then that she would give me back my freedom if our marriage didn't turn out. Well, it hasn't in three years, and now she refuses to divorce me." Asked what his wife had to complain about chiefly in him, he admitted that he "made some little mistakes". For instance, love letters from other women and his replies came "acciden-

tally" into his wife's hands. He was, he constantly reiterated, a "born bachelor", and considered himself justified in having extramarital relations. Now, unfortunately, his wife had "material" against him, and that "complicated the matter".

A conversation with Mrs. A., a smart-looking woman appearing not more than thirty (although she was forty), revealed that she considered her husband "a terrible liar, in every respect unreliable, mercenary, and good-for-nothing". She denied that she had forced him to marry her and pointed out what a good influence she had had on him. She admitted that they had rows, but shifted the responsibility completely to him. "I never made scenes before I discovered those letters, but afterward I wanted to know the truth." According to her, she fought only when her husband came out with "dirty lies". "If he would only confess, I would forgive him, but he lies like hell." Asked why she insisted on having all of the details she answered that she was afraid to meet people any longer, since she didn't know which were his girl friends and which knew about them, and was afraid of becoming a laughing-stock. Full of fury, she accused her husband of being a "block of ice". "Of course, he has the advantage, since when I react emotionally he calls me hysterical."

From the life story of Mr. A. one could gather that his beautiful mother had had the greatest influence on him, his father having been away often during his formative years. The patient emphasized the beauty of his mother, and it was evident that in his pseudo-charm he identified with her. Soon it became apparent that he had unconsciously a strong feminine identification. This tendency he counterated unconsciously with the pose of a Casanova and with intellectual disparagement of women. He gave, incidentally, as one of his reasons for allowing himself to "be married by" his wife, his desire to break away from his "polysexual life". Without consistence, he stated on the other hand that he preferred his bachelor life. In any case, it became clear that all of the "bad qualities" he accused his wife of having (especially those of an overbearing governess) were exactly the ones which could fulfill his inner wish of being overwhelmed in a feminine way. Unconsciously there was in that layer for them a complete reversal of the man-wife attitude: He played inwardly the rôle of the woman; she, that of the man.

Interestingly enough, the patient was sexually uninterested in his wife. He attributed his lack of interest to two facts: first, that she was not his "type" and, second, that her constant rows made sexuality impossible. The man was very potent but wanted to be seduced by his wife. She, however, played coy, and was rather passive in sex. One of the patient's chief objections to her was that, in a previous relation, she had actually seduced a man, a deed which she had mentioned to him as a practical joke when their acquaintance was slight. The patient dwelt constantly upon this deed, and more reproaches and more refusals in sex and money resulted. Despite the fact that his wife understood vaguely that her husband wanted to be seduced, she felt an inexplicable inhibition against "going back to the old times".

So far we see that the man wanted unconsciously to be overwhelmed in feminine identification—his wife was aggressive. He wanted, furthermore, constant hysterical rows, since they gave him the feeling of being mistreated—she also gave him that satisfaction. But all of these satisfactions were on the unconscious level. Consciously, he suffered "like a dog", to quote the patient. His wife provided for him only unconscious pleasures on a characterological level; their sexual life was highly unsatisfactory. There the inner defence on his part set in. What he really wanted was not genital satisfaction; he had used this satisfaction, in previous relations, to a great degree to establish the alibi of being a "he-man". Basically his being mistreated satisfied his sexual needs in a masochistic way. But his constant complaints against his wife represented his unconscious defence. Even in his defence he smuggled in his old wishes; by refusing pseudo-aggressively sex and money, he provoked more aggression on her part and started once more the vicious circle of being unjustly treated.

The strange part in his unsolved oedipal relation was that his wife did not represent his "type", whereas women he had known in previous relations did. Obviously this was because in marriage his defence had to go one step further in protecting him against his original wish, since it was easier to identify unconsciously his legitimate wife with his mother than girls of indifferent and transitory affairs. Therefore the defence had to go one step further—avoidance of his type. Even in his previous transitory affairs, however, it became obvious that our patient was not the great seducer, as he pretended to be. Quite the contrary; these women had to seduce him. By means of his constant infidelity he tried in vain to prove to himself that he was, not passive, but aggressive toward women.

It might be asked how it happened that a man who had escaped marriage until he was forty should finally have succumbed to it. The answer is that his original wariness against marriage represented an unconscious desire to avoid greater neurotic troubles, a form of self-preservation of the ego against greater inner danger. But, as is true of old bachelors when they marry, as they do often in their forties, his neurosis increased with age, and he eventually bargained for greater trouble—and got it. His increasing craving for neurotic pleasure was also visible in his unconscious concocting of the situation in which his wife found the incriminating letters. Neurotics at that age want to repeat their neurotic repertoire one hundred percent; innuendoes no longer satisfy them.

A few other facts are pertinent with regard to this patient. It was, of course, not true that his father played as unimportant a role in his life as he at first claimed. The patient was terrified of his father, and acquired thus strong castration fears which made it possible for him to shift from the identification with the father who possessed the mother ("positive" Oedipus complex) to identification with the mother wanting to be overwhelmed by the father ("negative" Oedipus). This feminine identification was repressed under the pressure of a strong feeling of guilt. Interestingly enough, the psychopathic trends (lies, unreliability, etc.) could be traced to another identification, with the sister of his mother, who was the black sheep of the family, having various psychopathic symptoms and signs. His idenification with her served different purposes: It satisfied the feminine trend in the patient, and could at the same time be used as an ironic weapon against the reproach of his inner conscience that he

had such an identification, the unconscious reasoning being, "I cannot be a woman since all women are as impossible as my aunt." In identifying partially with his aunt, the patient also displayed aggression toward his family, thus once more making a play for his typical defence mechanism, pseudo-aggression.

If we ask why this man married at all, we see that it was because his neurosis had increased, and Mrs. A. presented him with a first-class opportunity to reel off his neurotic pattern[3].

CASE II.—Mr. F., a man of forty-five, lived with his brother's family for many years. He introduced himself to me as the partner in a big business concern, and had the attitude of the successful businessman. He wanted to be analyzed because of marital difficulties. After long hesitation he had married a woman of thirty-five, or, more precisely, she had married him. He had had, long before marriage, a precise picture of his wife-to-be. She must come from an important family, with fine background (especially "money background"); she must be a virgin, a good housewife, and in general devoted and loving. Always on the lookout for such a miracle, he spent his years "working hard" and "building up the business". It soon became clear that his partnership in the business existed in his fantasy only. True, he had shares in the business, but his partner always arranged it so that he had to live on a moderate income, leaving the earnings in the concern. His "partner" slipped the wool over his eyes, not letting the patient understand the fact that a minority stockholder is always helpless against the majority stockholder, and showing the patient (the minority stockholder) always the increasing amount of money he had in the business—in shares, but never in income. Only when the patient, at his wife's urging and during analysis, demanded that his partner accept an agreement to buy his shares, if asked to, and met refusal, did he see with mounting fury that he was but a well-paid employee, giving his earnings without interest to the business, that is, to his partner. The patient, who was not naive otherwise, had thus damaged himself for eighteen years, living in a "fool's paradise", as he later admitted, counting on paper a fortune which would depreciate considerably at sale, since no one else wanted to become the associate of such a notoriously disagreeable person as his partner in the hopeless situation of a minority stockholder. Asked why he had never insisted on a real partnership or some definite agreement, he replied that he had hoped his partner would "have a heart". He obviously let the aggressive and not too scrupulous partner take advantage of him, knowing all along that his rôle was to be one of dependence, with the title only of vice-president.

His unconscious pattern in life, as shown by this incident, was to concoct a situation in which someone was unjust to him, to overlook for years the whole implication, then become pseudo-aggressive, seemingly in self-defence (his partner did not take his fury seriously) and pity himself masochistically. This mechanism[4] was the clue to his personality.

According to the patient's description, he was sexually completely normal until he married. He had had occasional sexual relations with girls, in which his potency had been satisfactory. He had hesitated to marry because the girls he met were "so superficial". He had been acquainted with his wife a few months when she "put him on the spot". She told him that she loved him dearly but that she had to think of her future, too; she was unhappy in her father's home, and another man had proposed to her, etc. Under this pressure, the patient married. Very soon—on the honeymoon—his disappointment started. His wife was not a virgin; her wonderful family background consisted of a crooked and miserly father; she was willful, overbearing, and reproachful, did not care for the home which the patient had furnished with great care and expense, and wanted only to have a good time.

We see that his actual choice of a wife represented a one hundred percent caricature of his "dream wife". As in regard to his business career, the question arises: "Was this man really so naive"? He was, but on the surface only; unconsciously he had constructed once more a situation where "somebody was unjust" toward him. That he had chosen this "unjust person" himself and, moreover simply for the sake of the injustice, only analysis could make him see.

His marital difficulties showed up first in a sense of depression, later in a disinclination to have intercourse, and finally in a specific form of potency disturbance, psychogenic aspermia[5].

The reason that he married at all could be answered precisely. He did so because his neurosis had increased. He married, not as he believed, to have peace and comfort, but to enjoy neurotic disturbances and conflicts. *His marriage did not cause the collapse of his neurotic equilibrium, maintained until he reached the early forties, but was the outward sign of his collapse.*

Conclusions

Summarizing our investigation, we can conclude that the elderly bachelor is always a neurotic who manages to maintain a certain amount of neurotic equilibrium as long as he doesn't marry. His aversion to marriage is a symptom of his neurosis, and at the same time, a means of protecting him against the full bloom of his latent neurosis. The critical age in which this protective mechanism of protracted bachelorhood typically collapses is the early forties or fifties. He then marries because his neurosis increases, not because he wants "at last" to do the normal thing. One gets the impression that the forties remind a person that his youth is ending, and his neurosis asks for a holiday in the form of exaggeration. The unhappy marriage achieved by such an individual is often accompanied by potency disturbances, the result of the collapse of his self-protective device. Such a man can be helped analytically[6], but only on the relatively rare condition that he understand that his neurosis is to be blamed for his difficulties, not his age, with its "habits of long standing". The majority of these sick people simply divorce their wives, or retreat from marriage at the last moment and continue to enjoy their pre-marital neurosis[7].

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[3]For details of the neurosis of both marriage partners, see the writer's paper, "Synchronization of Neurotic Behavior Patterns", to appear in *The American Journal of the Medical Sciences.*

[4]This mechanism, the "mechanism of orality", in pathognomic for a specific type of neurosis, and has been repeatedly described by the writer. A compilation is found in the monograph, "Psychic Impotence in Men". *Med. Ed.*, Huber, Berne, 1937.

[5]It is impossible to go into details here of this malady, which was first described by the present writer. It is discussed in case histories in "Further Contributions to the Clinical Picture of Psychogenic Oral Aspermia", *Int. J. Psychoan.* (London), 18:2-3, 1937.

[6]The two cases described here as Cases A. and F. were cured.

[7]The four hysteric cases described in the beginning of the paper belong in this group.

THE PSYCHONEUROSES

A Summary of the Literature

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Definition

It is difficult in the present state of knowledge, according to Wechsler, to define precisely what is meant by the term neurosis (or psychoneurosis). Essentially this is due to lack of knowledge of the ultimate cause or causes; but the difficulty also derives from confusion of terminology and conflict of point of view. At the present moment two schools of thought dominate the field: one of which defends the psychological or psychopathological point of view, and the other adheres to the organic, somatic or pathophysiological theory of the neurosis. A third approach attempts to correlate the two, since it is impossible to define the problem in either pure psychological or pure somatic terms. Psychopathology postulates the existence of unconscious mental processes which motivate normal as well as abnormal behavior and are regarded as the source of neurotic symptoms.

The following definition of the psychoneuroses by Moersch is a modification of one given by Yaskin: The psychoneuroses (neuroses) represent types of reaction characterized by a great variety of symptoms (subjective or objective) without any constant organic basis and generally traceable to some disturbance in the psychologic processes of the afflicted person.

From this definition it is apparent that psychoneurosis is not a specific entity but rather a pattern of adjustment that a person makes to the problem of living. In psychoneurosis there is a failure of adoption within the personality. The psychoneurotic symptoms arise owing to emotional reactions, which may be conscious or unconscious in origin. At times it is indeed difficult to distinguish between what is "neurotic" and what is "organic", as every disease has a somatic and a psychic content.

We agree with McCombs that within recent years it has become apparent that older ideas concerning the limitation of the definition of the psychoneuroses will have to be changed. It used to be believed that in so-called "functional" disturbances no pathological lesions could be demonstrated in end organs; many now believe, however, that long-continued psychological imbalance is capable of producing changes in the organs which are ordinarily considered to be "organic", such as the development of peptic ulcer. This is known as *psychosomatic medicine*. Many diseases formerly considered to be of unknown origin now are under study in an attempt to see if they may be the result of purely psychological disturbances. Certain organ systems are more frequently involved than others, namely, those which are closely connected with the autonomic nervous system.

Incidence

Psychoneurosis is probably the commonest medical disease. Most authorities agree that fully fifty percent of all adults have varying degrees of psychoneurosis, and in perhaps one-third to one-half of these persons the neurotic disturbances are serious enough to cause them to visit a physician. The others have vague chronic disturbances which they treat themselves or try to ignore.

Classification

A simple understandable and workable classification of the psychoneuroses is that adopted by the American Psychiatric Association and is as follows: 1, neurasthenia (exhaustion states, fatigue states, "battle fatigue", and so on); 2, obsession-compulsion neurosis (psychasthenia); 3, hypochondriasis; 4, hysteria; 5, anxiety neurosis (anxiety states), and 6, reactive depression (psychoneurotic depression).

The psychopathic states are frequently discussed in conjunction with the psychoneuroses. It is true that a psychopathic person may have symptoms of a psychoneurotic nature, but one must not confuse the psychoneuroses with the psychopathic states, which represent an entirely different group of neuropsychiatric disorders.

Etiology

McCombs states that heredity undoubtedly plays a large part in the development of neurotic traits in that certain persons are endowed from birth with poor quality of gray matter. Alvarez has labelled this group as having "constitutional inadequacy", which is an excellent term. They are chronically ill from a time early in life and are never able to make a satisfactory adjustment to the stresses and strain of life. One must not make the mistake, however, of considering all types of neuroses as hereditary, as the psychiatrists tell us it is possible to produce neurotic manifestations in anyone provided he is placed under severe enough strain.

Maladjustments to adolescence and erroneous concepts concerning sex are factors of importance in the production of the neuroses. Freud believed that the constant repression of sexual desires (libido), causes a conflict in the unconscious which leads an individual to a flight from reality and an evasion of his responsibilities in life. Certainly many neurotics have unsatisfactory sexual adjustments after marriage, but more often this is due to the neurosis than to anything else, and is rarely a primary cause of neurosis.

Various complex theories, according to McCombs, have arisen in an attempt to explain the development of the neuroses. Weir Mitchell believed that most cases could be explained upon a basis of "nervous exhaustion". Others have felt that many of the neurotic symptoms were due to "autointoxication" such as might develop even from constipation. Still others have advocated a "reflex theory" in which some minor disturbance of the body automatically causes generalized symptoms. Then there is the "endocrine theory" and the "conditioned reflex theory". There is certainly no definite evidence to corroborate any of these theories, and dependence upon these somatic theories necessarily directs attention away from the psychological defect and hence leads to faulty methods of treatment. The most common precipitating factors are fatigue, anxiety,

fear, worry and repeated frustrations. It must be remembered, however, that different degrees and duration of these conditions are necessary to produce neuroses in different individuals, much depending upon their heredity and background.

Symptoms

Moersch summarizes the cardinal symptoms of the more important psychoneuroses as follows:

Neurasthenia.—Neurasthenia is characterized by intense mental and physical fatigue, irritability, somatic symptoms, insomnia and mental depression. Under this heading are included the acute exhaustion states, fatigue states, "battle fatigue", and "flight fatigue". (Some writers include hypochondriasis and reactive depression under this heading.)

Obsession-compulsion neurosis.—The major symptoms of the obsession-compulsion neurosis are doubt, fear, incapacity of choice, scrupulousness and exaggeration of subjective and objective sensation. It tends to occur among officers and the prognosis is unfavorable.

Hypochondriasis.—Hypochondriasis consists of profound preoccupation with bodily organs and functions.

Hysteria.—Hysteria is a physical dissociation which leads to paralysis, anesthesia, movement disorders and disorders of special senses. As a rule there is no apparent serious mental conflict. The previous record of the patient may have been satisfactory. This type of neurosis is easily cured. It was the most common type of psychoneurosis encountered in World War 1.

Anxiety neurosis.—In the anxiety neurosis there is a psychic dissociation which results in severe mental conflict, intense anxiety, fear, apathy, depression, sleeplessness, dreams and tremor. It is deeply rooted and difficult to cure, and it is especially common among officers. It frequently is referred to as "neurosis of expectation" and as "anticipation neurosis". (Under this heading, neurocirculatory asthenia, effort syndrome and psychomatic disorders are usually placed.)

Reactive depression.—Reactive depression is an acute, usually transitory state of depression associated with anxiety, fear and inactivity. The depression is in response to trying situations.

It should be kept in mind that the various forms of psychoneurosis are not rigidly fixed but tend to merge into one another.

There are but few organic diseases which in the early stages of their development may not be mistaken for functional conditions. Unfortunately, the converse is true, namely, that a frank psychoneurosis may be suggestive of an organic disease.

Psychotherapy

The value of psychotherapy, according to Yaskin, may be summarized as follows:

1. Psychotherapy is useful in the treatment of all neuroses and neurotic manifestations complicating physical disease.

2. Psychotherapy is a psychological device used to change the attitude of the patient toward himself, toward his physical and mental processes and toward his environmental factors. It is an attempt to revaluate his various life problems in relation to his various symptoms in the light of intellectual but especially emotional experiences.

3. Rapport. This is a relationship between physician and patient whereby the latter gains confidence in and respect for the therapist, and at least a desire to cooperate despite preconceived notions of the origin of his symptoms. To attain the attitude of a satisfactory rapport the patient must feel that the physician not only sympathizes with him but also that he has a clear formulation of his case and has the ability to help him. The creation of the rapport begins with the taking of the history, which should be complete and recorded at once. Necessary laboratory procedures should be made and at times some special examinations, such as x ray studies, electrocardiograms, etc., even though the clinician's judgment does not warrant such procedures.

4. At this point the physician is in a position to inform the patient that his symptoms are not due to physical causes and to emphasize that his complaints are undoubtedly due to other causes which are in need of special treatment.

5. Desensitization. This consists of removing the unpleasant emotional tone attached to the memories by intellectual discussion. The patient is encouraged to face openly the unpleasant experiences and memories of the past. To accomplish this the material must be brought into consciousness repeatedly. This is done either by direct interviews or by the free association method.

As soon as the patient realizes that the doctor understands the immediate cause of his difficulties, he is much nore amenable to procedures directed toward uncovering the cause of his anxiety. Experience has shown that symptomatic treatment without an attempt to relieve the maladjustments which are responsible for the excessive cortical stimulation is unsatisfactory for both patient and physician. These maladjustments frequently can be recognized and corrected even by the general practitioner or internist. A large group, however, including the patients who shop around from physician to physician, have deep-seated conflicts. For these the help of a psychiatrist is required.

Freudian Principles

No discussion of the psychoneuroses would be complete without at least quoting some of the Freudian principles. Stripped of their scientific jargon they may be summed up in the following way:

1. There is no *chance* in mental life; every mental phenomenon—hence every nervous phenomenon—has a cause and a meaning.

2. Infantile mental life is of tremendous importance in the direction of adult processes.

3. Much of what is called forgetting is rather a repression, into the unconscious, of impulses which were painful to the personality as a whole.

4. Mental processes are dynamic, insisting on discharge either in reality or in phantasy.

5. An emotion may become detached from the idea to which it belongs and be displaced by other ideas.

6. Sex interests dominate much of the mental life where their influence is unrecognized.

7. By means of transference, which is a state of rapport between physician and patient, the repressed and unrecognized material is brought to the surface, to be dealt with by mature common sense.

General Discussion

In the differential diagnosis of weakness and fatigue a nervous condition may be assumed, according to Frank Allan, under the following circumstances:

1. When energy is low in the morning but improves during the day.

2. When periods of vigor are followed by days of exhaustion, with no change in activity to explain the difference.

3. When immediate benefit is experienced from the use of medication with slow pharmacological action, such as vitamins, thyroid extract, iron, liver extract and digitalis.

4. When the weakness immediately returns when customary treatment is omitted even for a single day.

5. When the patient never has felt really well.

6. When the patient claims to have been tired and weak for over three years without objective evidence of disease.

7. When the patient complains of nervousness, anxiety and worry with somatic symptoms, such as a lump in the throat, tension in the back of the neck, difficulty in getting a satisfying breath, or palpitation.

8. When the patient denies being nervous, but relates a multiplicity of complaints, with various emphasis on different symptoms, vaguely described, and demonstrates nervous behavior such as flushing and weeping during an interview.

Of course, one must not forget that not every nervous condition represents a neurosis.

The basis of all psychiatric investigation is a good history, which should include, besides the usual factual material, his loves, ambitions and frustrations. From the history, emotional responses and the content and interpretation of dreams, one is led to the cause of the psychological maladjustment. When the patient recognizes the relationship of his conflicts to his physical symptoms, he usually recovers. It must be admitted, however, that there will always be patients who are "psychopathically and protoplasmically" inferior and therefore not amenable to psychiatric treatment, who must be treated symptomatically as their various complaints are brought to the physician.

In the psychiatric approach, the patient should be considered as a person who is ill physically as well as emotionally. The rapport or positive transference from the patient to the physician is essential in the early phase of any modern psychiatric treatment. Again, for treatment to be successful, the neurosis must be regarded as an illness, which it is, and not as wilful maliciousness, which some inexperienced observers believe it to be.

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450 SUTTER STREET.

THE EPILEPTIC BRAIN AND ITS INFLUENCE ON HISTORY

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Epilepsy has been an interesting riddle for hundreds of years. Although it is now known that while various factors are responsible for epileptic seizures, the chief cause has been an irritated brain. The great majority of cases of epilepsy have been associated with various injuries of the brain, especially those which affect the parietal and frontal portions. Tumors, scars, injuries, degenerative and atrophic changes have been frequently recorded as factors predisposing to epilepsy.

Dr. K. Winfield Ney has been much interested in epilepsy from the viewpoint of the brain, and it is his contention that in epilepsy the brain is always irritated. There may be no gross alterations in its structure, nor scars or other noticeable defects, but a careful search will almost always show some disturbance in the brain.

In a series of 272 patients representing socalled idiopathic epileptic seizures, that is, epilepsy without gross brain defects, Dr. Ney found that there were various defects, small in themselves, but present nevertheless, which were responsible for the irritated brain and the convulsive seizures.

Arachnoidal defects or fistulas through which cerebrospinal fluid leaks into the subdural space have been found in practically every epileptic patient who has presented no other defect. These fistulas are probably the result of tears in the arachnoid which have failed to heal, and are usually located at the extreme vertex of the brain where the strain of gravity is greatest.

It is the belief of most brain surgeons today that there must be some underlying anatomical factor responsible for epileptic seizures. Considering the great weight of the brain, what maintains it in a state of postural stability within the cranial box? There are several factors, one of which is the pressure of the cerebrospinal fluid. Also, there are various strands of tissue which help to maintain the brain in a smooth, calm milieu. Any factor which causes an escape of cerebrospinal fluid from the brain or which causes tears in the fine strands of tissue, at once abolishes the normal postural stability of the brain. Irritative factors then come into play, and epilepsy becomes manifest.

One of the greatest students of epilepsy was Dr. Hughlings Jackson, and a type of epilepsy, due to intense irritation of a certain area of the brain, was named after him—Jacksonian epilepsy. According to Dr. Jackson, "Epilepsy is the name for occasional, sudden, excessive, rapid and local discharges of the gray matter. A convulsion is a clotted mass of innumerable movements produced by the excessive, sudden and abrupt cerebral discharges." Convulsions are due, he says, to the storing up in a portion of the cortex of the brain of an excess of energy in unstable equilibrium. It takes time to store up this energy so there is usually a space of time between convulsions. The crude outbursts of energy are followed by a period of fatigue in the portion of the gray matter giving rise to the convulsions, and for this reason there is often a temporary paralysis of the parts convulsed.

Epilepsy and leadership have gone hand in hand down through the ages. Many of the world's great men had irritated brains and epileptic incidents at regular intervals. Dr. T. C. von Storch points out that St. Paul, Mahomet, Luther, Loyola, Dante, Petrach, Pascal, Schumann, Richelieu, Byron, Paracelsus, Empodocles, Beethoven, Flaubert and Alexander the Great were a few of the illustrious men who suffered from epilepsy.

The great military geniuses were men with irritated brains. Alexander, Julius Cæsar and Napoleon were epileptic. The Roman historian, Suetonius, wrote of two of Cæsar's epileptic seizures. At Thapsus, according to Dr. Pirkner, Cæsar showed premonitory symptoms and, "shaken with tremblings and feeling the aura, had barely time to be carried into a tower, where the seizure overcame him. The premonitory symptoms were tingling and trembling lodged in one of his feet, which subsequently he felt rising through his whole body, and when they reached his head, he lost consciousness."

Napoleon had, on occasions, epileptic seizures. As reported by Dr. MacLaurin, in September, 1805, Napoleon was seized with an attack, fell to the ground, and struggled convulsively. This constant cerebral irritation probably led him on to greatness. Inner compulsions that could not be stayed are responsible for reaching out beyond that which a man with a calm brain would not dare to venture.

Great religious leaders were also men with seething brains, irritated by something within the brain that disturbed its equilibrium. Moses was an epileptic, and so was Mahomet, the founder of Islam. Dr. Pirkner says: "Mahomet would be seized with violent trembling, followed by a kind of swoon, or rather convulsion, during which the perspiration would stream from his forehead in the coldest weather; he would lie with his eyes closed, foaming at the mouth and bellowing like a young camel."

Saint Paul, the apostle who disseminated the Christian doctrine, was another of the world's spiritual leaders who had the epileptic taint. It is the belief of modern neurologists that his constant drive was actuated by an irritated brain, or at least one that was unstable, from the physiological point of view.

To analyze each of the foregoing cases of epilepsy with any degree of thoroughness would take far more space than is available for the present discussion. It will suffice to take one celebrated epileptic and discuss his case in some detail. Our choice is Gustave Flaubert, one of the world's great men of letters.

Flaubert was twenty-two years old when he had his first great epileptic seizure. It was in the month of October, 1843. Other attacks followed, four of them in two weeks. These fits all occurred in the same way and were preceded by the same symptoms. Suddenly, without any apparent reason, he would turn very pale and with an anguished expression would shrug his shoulders in a heart-rending gesture of discouragement, saying, "I have a flame in my right eye; everything seems golden color to me." This strange condition would continue for a few minutes, until becoming still paler and with a desperate expression on his face, he would run towards his bed and stretch himself out on it, as though he were lying down alive in a coffin. Then, with a cry, he would pass into the throes of convulsion. The paroxysm would be succeeded by deep slumber.

Gustave Flaubert was a typical genius with an irritated brain. To treat things lightly, to put his loves or his hatreds into perspective, was impossible for him; his method was always one of excess. It was in depicting indignation that his eruptions of violence and of paradox found their best expression.

Violence and excess, however, are not the only traits of character of which his style of writing bears the imprint. The hypersensitivity of the epileptic is equally marked. This almost feminine trait sometimes brought tears to his eyes, but more often it rendered him irritable and irascible, ready to fly into a rage at anything or nothing at all. When writing, the search for a word would throw him into a state of anger and he would thump the table with his fists. He would pass from the highest exaltation to the deepest depression with great rapidity and without apparent cause.

Flaubert suffered most of all in connection with rhythm and rhyme. Bouilhet said: "There is a curse upon him; he is a lyric poet who cannot write a verse." Flaubert writhed in his powerlessness. "And all the time I feel it inside me," he cried, referring to the beat of the rhythm which escaped him.

"There comes a moment when one feels a longing to make oneself suffer, when one hates one's own flesh and wants to throw mud in one's own face." At the same time, he said: "I love my work with a frenzied and perverted love, as an anchorite loves the hair cloth that tortures his body." Flaubert was a sadist and a strong touch of sadism is evident in much of his work. This characteristic is frequent among epileptics. Flaubert's favorite kind of hero, grotesque, pathetic, coarse, sententious, violent, obstinate and patient, is the model of the author.

The epileptic is not necessarily a physically incapacitated individual, nor is he constantly in the throes of convulsion. There are cases of subclinical epilepsy in which the victims are free from fits and whose condition is revealed only by taking an electroencephalogram of the brain's activity. Such a case is Hitler.

Hitler fits well into the classification of an epileptic. His continuous retreats to his mountain sanctuary at Berchtesgaden; his long spells of brooding, introspection and silent communion with himself; his mystic, visionary ideals are all indicative of the typical epileptic personality. He is one of the company of men with damaged brains who have exerted a profound influence on the course of history.

989 LAFAYETTE AVENUE

Editorials

The Surgery of Deafness

Recently a "lay magazine" published an article written by one of those literary lights who make a living by choosing a medical subject of popular interest, pumping "authorities" dry, and "translating medical verbiage into United States language." It is a good, and no doubt fertile field if you can till it, but it has certain repercussions. We refer now to a little essay on surgical cure of the deafened in a popular magazine which was rather well written, but, unfortunately cited the institutions where one might go to be operated upon. Result, at least two New York hospitals have been overrun by letters and inquiries from practically every state in the union. Some deafened did not stop to write but caught the first train available, then besieged the aural hospitals for relief. It becomes necessary, therefore, to clarify the situation for many physicians who are not otologists, but who are earnestly entreated by importunate deafened patients for information.

The only kind of deafness under consideration at this time as amenable to surgical relief is socalled *otosclerosis*. This is a disease which fixes the foot plate of the stapes (stirrup) in the oval window, and therefore, prevents air-borne sounds from sending vibrations through the inner ear to the organ of Corti where the cells and fibers of the auditory nerve send impulses to the brain. Histologically, there is much more to the story, but for present purposes this tissue change produces "progressive deafness".

Some years ago Professor Sourdille, of Nantes, France, began to experiment with a "window resection" of the bony capsule of the aural labyrinth which was, in effect, a short-circuiting procedure designed to allow air impulses to agitate the fluid in the labyrinth and thus carry these impulses to the hearing organ. In this country, Lempert, of New York, has been the chief exponent and has carried out extensive researches, largely clinical, which have popularized, or at least have made known to otologists a method which in some instances may restore or improve hearing that has been largely lost for conversation purposes. In the *Archives of Otolaryngology,* January 1945, Lempert has presented a long article, beautifully illustrated both by black and white and by colored plates, setting forth the variations in technique which he has wrought. "Clinical otosclerosis is thus converted into symptom-free otosclerosis." The histological condition remains the same, but the baneful effects on hearing loss are alleviated or removed. The "window" is cut in a semicircular canal or in the "vestibule" of the labyrinth, thus permitting sound impulses to stir the fluid within the internal ear and to carry these impulses to the organ of Corti which is comparable to the retina of the eye.

Although early successes of some eight or ten years ago promised much, defeat came either through a closure of the new opening by Nature or loss of hearing through the setting up of a serous labyrinthitis. These unhappy sequelæ have now been largely overcome through more rigid technique and the manufacture of a "mobile stopple" of cartilage or other tissue to cover the "fenestra nov-ovalis" or new window. One thousand patients have been operated upon by Lempert, three hundred of whom had the new opening in the external semicircular canal, and seven hundred in the surgical dome of the vestibule. "Practical serviceable hearing for all social and economic purposes was restored and continuously maintained in a large percentage of patients". Many audiograms are shown to substantiate this claim, and a method is outlined for computing and reporting end results. The operation is not free from danger. What operation is? But occasionally infection may take place and hearing may be completely lost on the operated side. For this reason, the poorer ear is usually chosen.

This operation affords relief in certain well-selected cases, in which the patients have tried hearing aids with dissatisfaction and are practically ostracized in ordinary room conversation. Perhaps one might call them "desperate cases willing to try anything for relief". One must remember, however, that even where improvement is marked, it may still be below the level required for serviceable hearing. Therefore, not too much should be expected. This writer has seen some enthusiastic postoperative patients, and some who are "sorry they had it done".

Calcium Deficiency

A proper diet is especially important in these war times, and as some of the substances needed to supply the necessary calcium content are relatively scarce, knowledge is needed as to the requirements of calcium for various classes of the community. Apprehension has been felt by some in regard to the effect of adding large quantities of calcium phosphate or carbonate to the diet because of the firmly held fallacy that calcium is bad for rheumatoid arthritis and gout. However, this is an exploded notion and it seems that the addition of a certain amount of calcium to flour for breadmaking would be a simple way of restoring and building up the calcium content of many poverty diets.

The action of calcium on the circulation is not thoroughly understood. Calcium appears to diminish the permeability of the capillary vessels and thus to prevent exudation of fluid outside them. This may be the

explanation of the beneficial action of calcium in chilblains and in urticaria. Calcium is absorbed rapidly when taken by mouth. It is said that the addition of small amounts of vitamin D tends to improve a condition in which the amount of phosphorus in the diet has a disturbing effect on the absorption of calcium. An explanation for the more satisfactory absorption of calcium on breast milk than on cow's milk rests on the fact that the former contains a greatly higher proportion of the natural vitamin D.

The young, of course, need a considerable amount of calcium and should be able to have a good allowance of milk daily. Those who are responsible for the upbringing of children should be taught the value of milk and should be enabled to obtain quantities adequate for the proper nutrition of young children. Calcium is required for growing persons and the old, and to a lesser extent for adults and should be available in the diet of all.

Trench Foot

Reports received at the Surgeon General's Office from the Army General Hospitals at Camp Butner, N.C., and Camp Carson, Colo., which are trench foot treatment centers, indicate that the cases now under treatment are for the most part mild. Lieutenant Colonel Roy H. Turner, M.C., who recently returned from an inspection tour, stated that, with the exception of a small percentage of cases, evidence of injury to the feet is slight and recovery is both rapid and exceedingly satisfactory. Colonel Turner believes that the mildness of trench foot cases now being hospitalized is largely due to the Army's intensified education of troops concerning trench foot which has resulted in the prompt reporting of cases, early diagnosis, and immediate treatment.

News Items

Harvey Society.—Dr. William F. Windle, professor of neurology, Northwestern University Medical School, Chicago, delivered the seventh Harvey Lecture at the New York Academy of Medicine on Thursday evening, April 19th. His subject was "Respiratory conditions in the fetus and effects of their impairment".

Friday Afternoon Lecture.—Dr. Clifford B. Lull, clinical professor of obstetrics, Jefferson Medical College, Philadelphia, delivered a lecture at the New York Academy of Medicine on Friday evening, April 20th on "Indications and contraindication for caudal analgesia".

Venereal Disease Control Course at Harvard.—A short intensive course on venereal disease control will be presented at the Harvard School of Public Health May 28th to June 15th by Dr. Walter Clarke, clinical professor of public health practice at Harvard University. This course is intended primarily for regular candidates for degrees of master of public health.

Graduate Fortnight at the Academy.—The eighteenth graduate fortnight of the New York Academy of Medicine will be held October 8 to 19th. Subject for discussion will be "Contributions of the war effort to medicine."

Dr. Svedburg Honored.—A memorial volume of 729 pages has been issued by the University of Uppsala, Sweden, in honor of the sixtieth birthday of Dr. The Svedburg, professor of chemistry at the University and director of the Institute of Physical Chemistry.

Penicillin Research.—The Rockefeller Foundation has granted to the University of Oxford the sum of twelve hundred pounds for biological investigations of penicillin for the year beginning March 1st. This research work will be conducted under the direction of Sir Howard W. Florey, professor of pathology.

Symposium on Penicillin.—At a stated meeting of the New York Academy of Medicine, held on May 3rd, Major Charles H. Rammelkamp, M.C., A.U.S., consultant to the Secretary of War, read a paper on the factors determining the dosage of penicillin in the therapy of infections; and Dr. Donald G. Anderson, instructor in medicine, Boston University School of Medicine, read a paper on clinical observations on the treatment of various infections with penicillin.

Maxillofacial Injuries.—A survey of the North African and Sicilian campaigns showed that of the total admissions to hospitals 0.5 percent were for maxillofacial injuries, and of these, forty-two percent were battle casualties, according to a release from the Surgeon General's Office. The incidence of maxillofacial injuries compared to total battle casualties was about twenty-two percent. In the cases reported, no deaths were caused primarily by battle-incurred maxillofacial injury.

Pioneers of American Medicine.—An exhibition of oil paintings depicting dramatic scenes in the history of American medicine, was held by Dean Cornwell in the Enoch Pratt Library, Baltimore, Md., April 23rd to May 12th. These paintings constitute the series on Pioneers of American Medicine which he has done so far for Wyeth Incorporated. They are: Conquerors of Yellow Fever, Beaumont and St. Martin, Osler at Old Blockley, The Dawn of Abdominal Surgery, and The Father of American Pharmacy.

National Society for Prevention of Blindness.—Dr. R. Townley Paton, New York, Mr. Clarence G. Michalis, and Charles Sheard, Ph.D., of the Mayo Foundation for Medical Education and Research, have been named members of the board of directors of the National Society for the Prevention of Blindness, Inc. Dr. Willis S. Knighton, New York has been named chairman of the committee on glaucoma, and the members included: Major Fred Heffinger, superintendent, and Dr. F. L. P. Koch, chief of the glaucoma clinic, Manhattan Eye, Ear and Throat Hospital.

Greater New York Fund.—The eighth annual campaign of the Greater New York Fund was begun on May 2d. The goal is a minimum of $4,500,000 to be divided among 408 voluntary hospitals, health and welfare agencies all serving in the New York area. These agencies include: 106 hospitals and medical care agencies, twenty nursing and health agencies, forty-three agencies helping families and unattached adults, eighty-nine child welfare agencies, twenty-five institutions for the aged, 119 recreation and group work agencies, and seven coordinating services.

Civilian Committee to Aid Army's Program for the Blind.—An honorary civilian advisory committee to the Surgeon General has been formed to cooperate in the Army's social adjustment training program for the blind. All members of the committee are individually prominent in civilian work for the blind. At the first meeting, held on March 21st, at the American Foundation for the Blind in New York City, Dr. Robert B. Irwin, of New York, was elected chairman, and Mr. Joseph G. Cauffman, of Overbrook, Pa., secretary. Mr. Peter J. Salmon, of Brooklyn, N.Y., Mr. W. L. McDaniel, of Washington, D.C., and Mr. Henry P. Johnson of Tampa, Fla., were elected field consultants. These constitute the executive committee.

Typhoid Carriers.—At the close of 1944, four hundred and eighty typhoid carriers were under supervision in upstate New York, according to *Health News*. During the year, forty-one new carriers were added to the register. Twenty-three of these were discovered as a result of investigating sporadic cases of typhoid, four by means of release cultures, ten accidentally, one on the basis of information from the New York City Health Department, and three were carriers who had been residing temporarily out of the State. The names of thirty-five carriers were removed from the register. Of these, twenty-three had died, six were released from restrictions, and six others had moved outside the jurisdiction of the Department.

Colonel Beeuwkes Retires.—Colonel Henry Beeuwkes, M.C., commanding officer of Valley Forge General Hospital since its inception two and a half years ago, has been retired from active duty. He was graduated from the Johns Hopkins University in 1909 and entered the Army the same year. Colonel Beeuwkes resigned from the Army in 1924 to study yellow fever in Brazil, and in 1925 he went to Africa to study yellow fever there, serving as director of the West African Yellow Fever Commission from 1925 to 1934. Colonel William E. Vaughan, M.C., formerly commanding officer, Stark General Hospital, Charleston, S.C., has been appointed to succeed him.

United Medical Service Elects Officers.—Formal election of officers and board members who have been serving in a temporary capacity since the foundation of United Medical Service, Inc., in June 1944, marked the first annual meeting held recently in New York. To serve for one year: Dr. Nathan B. Van Etten, chairman of the board and of the executive committee; Rowland H. George, president; Dr. Charles Gordon Heyd and Frank Van Dyk, vice-presidents; Paul G. Drescher and Harry Sesan, assistant vice-presidents; John S. Linen, treasurer; Dr. DeWitt Stetten, secretary, James de Socarras, assistant secretary; and Dr. Frederic E. Elliott, director of Medical Service. Board members and chairmen of standing committees: Dr. Harry Aranow, nominating committee; Mr. Linen, finance committee; and Dr. Milton J. Goodfriend, Physicians' Review Committee. Others elected to serve on the board are Dr. Frank L. Babbott, William C. Breed, Jr., Dr. Edwin S. Burdell, Dr. Thomas M. d'Angelo, Dr. Chester O. Davison, Dr. M. J. Fein, Dr. Arthur Hunter, Dr. David J. Kaliski, Reverend Francis P. Lively, Dr. John J. Masterson, Walter Mitchell, Jr., Stanley Resor, the Honorable Jane Todd, Dr. M. D. Touart, the Honorable Charles A. Voss, George M. Wells, and Dr. I. Ogden Woodruff.

Treatment of Acute Poliomyelitis.—The Greater New York chapter of the National Foundation for Infantile Paralysis, in collaboration with the Willard Parker Hospital, held a meeting at the New York Academy of Medicine on Thursday evening, April 26th, with Dr. William W. Herrick, president of the Academy, presiding. The main subject for discussion was the "Treatment of acute poliomyelitis with demonstration of the use of the respirator". Dr. Don W. Gudakunst, medical director of the National Foundation discussed the treatment of poliomyelitis in 1945, and Dr. Philip M. Stimson, associate professor of clinical pediatrics, Cornell University Medical College, read a paper on the treatment of acute poliomyelitis, with a demonstration of the use of the respirator. After the formal meeting, there were further demonstrations of the care of patients in the acute stages of the disease.

New York Cardiological Society.—At a meeting of this society held at the New York Academy of Medicine, on Wednesday evening, April 25th, the annual report of the committee on scientific progress was presented: Therapeutics by Dr. Anna Samuelson; electrocardiography, by Bruno Kisch; literature by Dr. Charles J. Brim. Commander Albert S. Hyman, M.C., U.S.N.R. who recently returned from an extended tour of duty in the Pacific, read a paper on heart disease in the tropics, which was followed by an interesting discussion. A report was presented on continuing the project on heart and trauma, which included statistics. This also brought out an interesting discussion. At the close of the scientific program, an executive session was held for the election of officers.

Passano Foundation Award.—Dr. Edwin J. Cohn, professor of biochemistry at Harvard University, has been chosen as the first winner of the award of $5,000 of the Passano Foundation. The foundation, which was established in 1944 by the Williams and Wilkins Company, proposes to aid in any way possible the advancement of medical research, especially research that bears promise of clinical application. For the encouragement of such research the foundation has established the award as one of its activties. Dr. Emil Novak, associate in gynecology in the Johns Hopkins University Medical School; Dr. Nicholson J. Eastman, professor of obstetrics, and Dr. George W. Corner, director of the Embryological Laboratory of the Carnegie Institution of Washington, represent the medical profession on the board of directors of the foundation.

Tropical Disease Hospital in Texas.—Harmon General Hospital at Longview, Texas, has been designated for the treatment of tropical diseases. The only other Army tropical disease center is Moore General Hospital at Swannanoa, N.C. The medical staff of Harmon General Hospital has for some time been engaged in a study of relapsing malaria which has resulted in a permanent contribution to the knowledge of the disease, and this study is now being extended to other tropical diseases which are rare in this country, such as filariasis, schistosomiasis and dysentery, according to a release from the Surgeon General's Office. The Commanding Officer of the hospital is Colonel Gouverneur V. Emerson, M.C., Lieutenant Colonel Worth B. Daniels, M.C., is chief of the Medical Service and Lieutenant Colonel Stuart W. Lippencott, M.C., is chief of the Laboratory Division.

Personal.—Major Clarence S. Livingood, M.C., has been appointed consultant in dermatology to the Surgeon General, U.S. Army.

Dr. Nelson Russell, who had been associated with the University of Buffalo School of Medicine for fifty-three years was recently presented with the Chancellor's Medal of the University "in recognition of a lifetime of eminent service to the profession, community, and country".

Dr. Albert D. Kaiser, who became health officer of Rochester, N.Y. on March 29th, has been appointed professor of child hygiene at the University of Rochester School of Medicine and Dentistry.

Dr. Ira V. Hiscock, who was recently appointed chairman of the Public Health Department of Yale University to succeed Dr. C.-E. A. Winslow, has been awarded the Legion of Merit for his work in typhus control in liberated countries.

Dr. Paul N. Gross, head of the department of chemistry, Duke University, has been awarded the Herty Medal of the State College for Women of Milledgeville, Ga., in recognition of his research on tobacco.

Dr. Ralph Pemberton, professor of medicine in the Graduate School of Medicine of the University of Pennsylvania, has been elected president of the Pan-American League for the study and control of rheumatic diseases.

Dr. Peyton Rous, of the Rockefeller Institute, delivered a series of Sigma Xi lectures on cancer at various universities and colleges throughout the United States, through the period from March 30th to May 9th.

Dr. Sidney C. Madden, associate professor of pathology at the School of Medicine of the University of Rochester, has been appointed professor of pathology and chairman of the department at the School of Medicine of Emory University. He succeeds Dr. Roy Kracke, who resigned last summer to become dean of the School of Medicine of the University of Alabama.

Dr. Gilbert Dalldorf, since 1929 director of laboratories of Grasslands Hospital, Valhalla, Westchester County, N.Y., has been appointed director of the Division of Laboratories and Research of the New York State Department of Health to succeed Dr. Augustus B. Wadsworth, who has retired.

Captain Waltman Walters, formerly of the Mayo Clinic, Rochester, Minn., who returned recently from the South Pacific area, has been appointed chief of the division of surgery of the U.S. Naval Hospital at Philadelphia.

Dr. M. Y. Dabney, Birmingham, Ala., was named president-elect of the Southern Medical Association, at the annual meeting held recently in St. Louis.

Dr. Stephen H. Watts, former professor of surgery at the University of Virginia, has added a gift of $5,000 to an earlier gift of $15,000 to be used as a book fund for the medical library.

Dr. Robert H. Felix has been appointed medical director of the Mental Hygiene Division, Bureau of Medical Services, Public Health Service, succeeding Dr. Lawrence Kolb, who retired on October 31st.

Dr. George C. Stevens, formerly director of the division of mental hygiene of the Indiana State Department of Public Welfare, has been appointed director of the newly established mental hygiene division of the Washington State Department of Health.

Army X Ray Conference.—An x ray conference was held March 27th, 28th and 29th at the Medical Department Equipment Laboratory, Carlisle, Pa., and was attended by representatives of the Army Service Forces, Army Ground Forces, Army Air Forces and U.S. Navy, together with representatives of industrial companies manufacturing x ray equipment. Improvements in present x ray equipment and requirements for future development were discussed. Among those from the Surgeon General's Office who attended the conference were Lieutenant Colonel J. B. Klopp, M.C., chief of the development branch of the technical division who presided the first day, and Lieutenant Colonel Howard B. Nelson, P.C., chief of the supply coordination branch, Captain Charles R. Tittle, M.C., Captain Howard A. B. Bliss, SnC., all of the technical division; and Lieutenant Colonel Charles G. Gruber, SnC., chief of the maintenance branch, and Captain Marvin B. Medlin, both of the supply service. The conference ended with a demonstration of captured German x ray equipment.

Irvington House Becomes Affiliated with New York University of Medicine.—The New York University College of Medicine, New York, and Irvington House, sanatorium for cardiac children, Irvington, have established a medical affiliation to further the care and rehabilitation of underprivileged children with heart disease, according to *J.A.M.A.* Under the terms of the affiliation the college of medicine of the university will be responsible for the direction, supervision and administration of the medical and research program at Irvington House, the announcement stated. The sanatorium will be used as a teaching center to train young doctors in the early recognition and treatment of rheumatic heart disease. While the New York University College of Medicine, under the terms of the affiliation, will have full medical responsibility for the direction of the institution, Irvington House will continue to depend on an annual appeal for voluntary contributions for its financial support. One of the major results expected from the new affiliation, according to Dr. Donal Sheehan, acting dean of the college of medicine, is an expansion of the sanatorium's research activities in the cause, prevention and treatment of rheumatic fever.

Grants for Sugar Research.—Dr. Robert C. Hockett, scientific director of the Sugar Research Foundations announces that six grants amounting to $45,000 have been made available for research into new industrial and nutritional uses of sugar. Among the scientists to whom the grants were made are: Dr. Pauline B. Mack and associates of the Ellen H. Richards Institute, Pennsylvania State College, $20,000 for one year, to measure the effect of high and low sugar containing diets upon the health, growth and physical condition of children; Dr. Rachmiel Levine, director of metabolic and endocrine research at Michael Reese Hospital, Chicago, $7,500 for one year, to study the physiological behavior of levulose; Dr. I. L. Chaikoff, associate professor of physiology at the University of California, $7,400 for two years, to study the protective action of sugar against cirrhosis of the liver; and Dr. I. M. Rabinowitch of McGill University Medical School, Montreal, $2,500 for one year, to study further the body's relative rate of absorption of sucrose, dextrose and levulose.

Book Reviews

Psychoanalysis

Psychoanalysis Today. Edited by SANDOR LORAND, M.D. Foreword by SMITH ELY JELLIFFE, M.D., Ph.D. Medical War Books. New York: International University Press, 1944. Pp. 404. Price $6.00.

This monograph on modern psychoanalysis reveals man as a little wayside station on the infinite trail of life. For himself—as a living feeling organism—he is the whole of life, and, even in the cosmic sense, as a time-binding animal he contains all of the past and the hope of an equal span of the future. That hope must meet with the wise use of his past patternings, else it is futile, and in that struggle between the reality and the pleasure principles lies the glory and tragedy of his success or failure in making the best use of his heritage.

The thought is as old as Homer who spoke of the soul as active in all parts of the body. It is repeated in the language of religion when it is said that man is made in the image of God, i.e. of Creation. It is made more concrete and biological in the language of psychoanalysis wherein one speaks of the theory of "instincts" and of being lived by the "id," i.e., by the primary impulses of action patterns which operate because of their survival value.

Of many of the present-day formulations of these action patternings, this collection of essays offers penetrating and illuminating pictures. Psychoanalysis is a young, vigorous, and growing science. Its founder and the active group of students here represented in part have had an opportunity to grow and to change their ideas as new discoveries in an untrodden field have shown earlier formulations to be incomplete. It would be presumptuous to claim that these present contributions represent immutable laws; such dogmatic attitudes have from the beginning been resisted by Freud and his co-workers. They merely represent present day attitudes and, as partial pictures of a progressive body of growing truths, they are offered with the conviction that they will serve as worthy agents in furthering human progress.

Tuberculosis

Tuberculosis of the Ear, Nose, and Throat: Including the Larynx, the Trachea, and the Bronchi. By MERVIN C. MYERSON, M.D. With numerous illustrations by Dr. Joseph Hersh, principally. Springfield and Baltimore: Charles C. Thomas, 1944. Pp. 291. Price $5.50.

The author's experience is based on a study of over one thousand cases in the King's County and Sea View Hospitals in Brooklyn and in other institutions as well as in private practice. He has written a painstaking and thorough clinical report on a highly specialized subject.

About one half of the volume deals with the larynx. The rest is devoted to tuberculosis of the oral cavity, tongue, pharynx, tonsils, esophagus, trachea, bronchi, and to the nose and ears. Of all these, tuberculosis of the larynx is the most important. It occurs about equally in male and female patients between twenty-one and thirty years of age, is rare in children, and has little to do with occupation save in persons working among the tuberculous or under what may be called "lung trauma" conditions. It is usually secondary to pulmonary tuberculosis, although it may be, rarely, primary.

Dr. Myerson thinks that the invasion is via the blood. He is not convinced that either the lymphatic system or direct contact of bacilli-laden sputum are causative. He will find some opposition here, but he says that "more larynges are bathed in sputum-laden pus and continue uninvolved than become infected." Sites most common are arytenoids and the interarytenoid or posterior commissure, extending along the aryepiglottic folds. Symptoms are hoarseness, dysphagia, and pain, but "the impression that hoarseness is the first symptom . . . should be corrected." Nevertheless, on page 75, hoarseness is set down as first in 856 patients out of 1,000 plus! Myerson prefers "indirect examination" to "direct" in nearly all cases, since the latter may prove "harmful" to an active lesion.

Tuberculosis of the middle ear is not so uncommon, Myerson thinks. It is insidious. There is discharge only, at first, with multiple perforations or wide destruction of the drum. Finding the tuberculosis organism may prove difficult, but search should be repeated many times. In the nose, tuberculosis is fairly uncommon, but does exist, often as a granuloma or tuberculoma. It is seldom primary.

Here is a book which should be kept for reference as it ranks "standard" in its field.

Pain in Childbirth

Control of Pain in Childbirth. Anesthesia, Analgesia, and Amnesia. By CLIFFORD B. LULL, M.D., F.A.C.S., clinical professor of obstetrics, Jefferson Medical College, and ROBERT A. HINGSON, M.D., Surgeon, U.S. Public Health Service. With an introduction by Norris W. Vaux, M.D. With one hundred illustrations. Philadelphia, London, and Montreal: J. B. Lippincott Co., 1944. Pp. 356. Price $7.50.

This is in all respects a Philadelphia book, which is to say that it is a good book coming as it does out of experience derived from a great medical center. The subject is not new, in fact it is very old, but the treatment of pain in childbirth by bringing together in one volume all that has been said and written which is of importance, or so deemed, is to this reviewer at least, entirely new.

There have been drugs and combinations of drugs for the relief of women in travail from time immemorial. Many of these have served the mother well, but have brought death or disability to the child. Ether, ethylene, nitrous oxide and oxygen, morphine and scopolamine, and "twilight sleep"; all these have had their day, and mostly have ceased to be. The latest and best method at this writing seems to be "continuous caudal anesthesia or analgesia". Three methods of administration are described (page 169). In three thousand cases the authors have used the "special malleable needle technic with closed apparatus." Breaking needles have been a source of great anxiety. The malleable needle seems to solve this problem. An initial dose of thirty cc. of a 1.5 percent solution of metycaine is injected with the onset of pains and definite beginning of labor. Supplementary doses are discharged at intervals of from forty to ninety minutes. There is, of course, much more to the method than this, and only a careful reading of the text will make it understandable. The value seems to lie in safety to both mother and child with few or no postpartum complications. Since most babies are delivered by that beast of burden the "general man", here is another indispensable morsel of information which he must chew and digest. He deserves both sympathy and praise if he is still doing obstetrical work.

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MAY 1945

Medicolegal Notes

Medical Expert Evidence—Effect

The fact that a medical expert's testimony on the trial is in conflict with statements previously given by him has a bearing only upon his credibility and the weight of his testimony, which are for the jury. Kundiger vs. Metropolitan Life Ins. Co., Minnesota Supreme Court, 15 N.W. 2d 487, 492.

An employee was struck on the right leg below the knee by a heavy iron beam, was given first aid and continued working. Some days later his leg became infected. He was sent to a doctor, went to bed for a week, was off work for two weeks, and then returned to work. The infected leg did not heal and treatment continued. Sulphanilamide taken internally cleared the infection about four months after the injury occurred. The insurance carrier paid two weeks' compensation and the subsequent doctor's bill. The employee sued under the Nebraska Workmen's Compensation Act, claiming that as a result of the accident he had developed a hydrocele on the left side, permanent in character and requiring additional medical and surgical treatment. Both doctors in the case testified that the etiology of a chronic hydrocele such as the plaintiff had is not known to the medical profession and that there are no cases in the medical books showing that a hydrocele has been caused by an infection such as the plaintiff had. The plaintiff's evidence went no further than to indicate that there might possibly be a connection between the two. That was not sufficient to sustain a recovery. "A compensation award cannot be based on possibilities or probabilities." Chambers v. Bilhorn, Bowers and Peters, Nebraska Supreme Court, 16 N.W. 2d 173.

Privileged Communications Statutes; a Novel Point

The New York statute, Civil Practice Act Sec. 352, by its express terms applies to information acquired by a physician in attending a patient in a professional capacity, and the rule is well settled in New York that there is no violation of the statute unless the relation of physician and patient exists. Therefore, since the relations between a patient committed to a mental institution and the official in charge of that institution is not the professional relation contemplated by statute. And an action will not lie by the patient for a breach of that statute.

But Mental Hygiene Law, Sec. 84, makes it the duty of the person in charge of such an institution to make a case record of the mental condition, bodily condition and medical treatment of each patient committed, which shall be accessible only to himself and his subordinates, except on order of the Commission or a court of record. For a breach of such duty the common law provides a cause of action for damages. Munzer v. Blaisdell, Special Term, Aug. 14, 1944, 49 N.Y.S. 2d 915.

Wartime Lighting of Hospital Entrance Held Sufficient

In an action by a nurse against a hospital for damages for injuries sustained because of the alleged insufficient lighting of the entrance to the hospital, the hospital's defense was that it was not responsible for plaintiff's injuries because the lighting facilities which it did maintain were those required to be maintained under military authority in wartime for a dim-out area. New York City Court, New York County, Fellman vs. Lebanon Hospital Ass'n, 44 N.Y.S. 2d 352 holds that a hospital corporation cannot be charged with negligence in the matter of lighting where it has complied with proper governmental authority, civil or military, and has supplied the lighting prescribed by that authority.

Aggravation of Hodgkin's Disease by Trauma

In a death claim proceeding under the Kansas workmen's compensation act, the Kansas Supreme Court held, Hall vs. Kornfeld-Harper Well Servicing Co., 151 P. 2d 688, that the medical evidence sustained the trial court's finding that Hodgkin's disease was aggravated and accelerated and the workman's death hastened by an accident which arose out of and in the course of his employment; and that the medical evidence on the point was not too speculative to support judgment for the claimant. Five doctors testified. One said he did not know the cause of Hodgkin's disease, so would not give his opinion as to whether it might be caused or aggravated by trauma. Two were of the opinion that trauma would injure tissue affected by Hodgkin's disease. Two were of the opinion the disease could not be affected by trauma. The weight of this evidence was for the trial court; not for the appellate court.

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Critique

Starvation Therapy While nutritionists and food concerns combine to make us eat more, it is quite probable that even a full diet tends to promote certain diseases, while starvation therapy has its place in the scheme of things. Young animals may easily grow so fast as to lose out in later life. Acceleration of either mental or physical maturity is of dubious wisdom.

Years ago Dr. Edmund Spriggs in the *Lancet* (March 9, 1929) insisted that fasting is beneficial in appendicitis, peritonitis, and ulcers. He recommended usually not a complete absence of food but restriction to one thousand to thirteen hundred calories. However, Dr. Spriggs held that fasting in an otherwise healthy person decreased resistance to infectious diseases, but this conclusion has been seriously questioned. The whole subject is still clouded. (See editorial, *J.A.M.A.*, April 6, 1929.)

Food in 1945 We will not starve in 1945. That now appears pretty certain, novelist and fictionier Bromfield to the contrary notwithstanding. Indeed, in 1944 we ate seven percent more food per capita than we did in the pre-war years 1935-39, but we produced about thirty-six percent more food than we did in the pre-war years too. However, demands, especially home civilian, were greatest.

There will, of course, be local shortages and gluts. There will be tight situations created by black markets. Government buying is, however, well spaced now, so as to take foods at the peak of production and interfere with consumer markets as little as possible. Furthermore, the War Food Administration has a well-developed mechanism for the regular resale of foods, to cut inventories and other purposes, in such ways as not to upset normal markets.

The civilian food supply is expected to remain at about the same level in 1945 as in 1944, if not of the same composition. Supplies of some fruits, turkeys, and beef may be larger, but supplies of pork, potatoes, butter, and probably of chicken and some fresh vegetables may be smaller in 1945. The end of the war in Europe, for which we have long looked too optimistically, will not change this situation much, nor will it lessen the tight spots in food.

During 1944, supplies of most manufactured dairy products—cheese and butter especially—of canned fruits and vegetables, the better grades of beef, and turkeys were short of civilian demand at ceiling prices. But relatively large supplies of cereals, lard, margarine, eggs, pork, canned fruit juices, and the principal fresh fruits—citrus especially—have been available to civilians.

In 1945, civilians will get less pork, more beef, and probably less meat over-all than in 1944, when our meat consumption ran 140-145 pounds per capita. But 1945 meat consumption will still top the 126-pound average per capita in 1935-39. Egg consumption will be lower in 1945, and chicken supplies also will be reduced. Butter supplies will be tight, though fluid-milk supplies will continue at a near-record level. Less lard will probably be available because of reduced hog slaughter, but supplies of shortening and edible oils will be as high as in 1944, though lower than in 1943. Margarine supplies will be larger.

Supplies of fresh and processed fruits and vegetables depend so largely upon seasonal production that little can be said other than that we shall probably be no worse off as a whole than we were in 1944. Our tremendous wheat crop and our good crops of other cereals give us an abundant supply both for human food and animal feed.

It is true that persons in the armed forces eat over half as much again as they did while civilians. It is also true that the armed forces and our allies combined, with a little relief, absorb twenty-five percent of our food production. But even then civilians are left more food per capita than before the war, they eat more than they did before the war, and they would buy more still if it were available at ceiling prices.

Future of Surgery In *J.A.M.A.*, April 6, 1929, Dr. Lewis Hugh McKinnie repined about unnecessary operations and the poor work done by surgeons. He said subsidy by Federal, State, and private agencies, paid to medical schools, seemed necessary to prevent these evils and to provide qualified graduates. He doubted the wisdom of having a single degree for surgeons and other physicians. He made a plea for a degree in surgery and declared that the surgeon had so far ranked too much as an artisan. Look up the article if you want to find what future he predicted. Has this future come to pass?

Sugar Absorption Advertisers have long tended to make us believe that sugar appears in the muscles a few minutes after ingestion and is therefore a superlative food. They forget that the disaccharide sucrose has first to be inverted before the sugar can even appear in the blood. The delay is not long, but there is a delay and, during that time, the body has to do work on the sugar. The advertisements seldom make clear that the product which reaches the muscles is a monosaccharide derivative.

Alcohol In *Science*, April 5, 1929, L. D. Seager, D. J. Verda, and W. E. Burge, of the University of Illinois, announced that alcohol, in addition to serving as a source of heat and energy, which makes it decidedly a food, also appears to stimulate metabolism. In particular, alcohol stimulated sugar metabolism almost as much as fat and protein.

Sex Differences Some years ago A. S. Lewerenz (*Journal of Educational Psychology*, 19, 629, 1928) reported on tests of a thousand unselected, comparable, school children, third-grade through high school. The girls were superior to the boys in only two of the nine abilities tested. They had more originality and they recognized colors better. But girls were more conservative. The boys dared more. They had more ability to scrutinize and analyze, though the girls had a greater sense of rhythm. Other studies indicate that boys reason better than girls and are interested in history somewhat earlier. But relative abilities change with age; now one sex and now the other shows to greater advantage. (See also *Journal of Education*, 6, 175, 1928.)

—THE CRITIC

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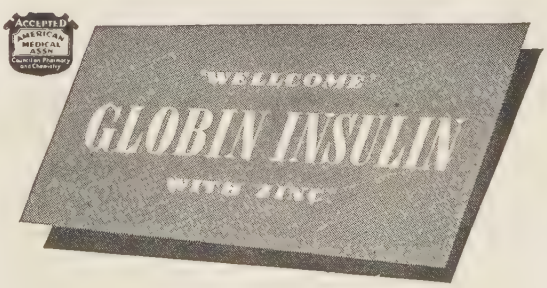

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Fellowships in Health Education

Fellowships for graduate work in health education are being offered to qualified applicants by the United States Public Health Service, in cooperation with the National Foundation for Infantile Paralysis, Surgeon General Thomas Parran has announced. These fellowships for the fall term of college, 1945, are being awarded to meet present and future needs for trained health educators in schools, communities, and local, State, and Federal health departments.

Men and women between the ages of twenty-two and forty who are citizens of the United States and who hold a bachelor's degree from a recognized college or university may apply. Fellowships will lead to a master's degree in public health. The twelve months' training period will consist of nine months in the School of Public Health at the University of North Carolina, Yale University, or the University of Michigan, and three months' field experience in community health education under supervision. Applicants must meet the requirements for admission to the Schools of Public Health. Training in science, sociology, education, and psychology, plus experience gained from working with people are desirable prerequisites. The fellowships provide a stipend of $100 a month for twelve months, full tuition, and travel for field experience. Candidates must pay the expense of travel to and from the university at the beginning and end of training.

Fellowship application forms may be obtained from the Surgeon General, United States Public Health Service, Washington 14, D.C. Applications must be accompanied by a transcript of college credits and a small photograph, and must be in the office of the Surgeon General not later than June 1, 1945.

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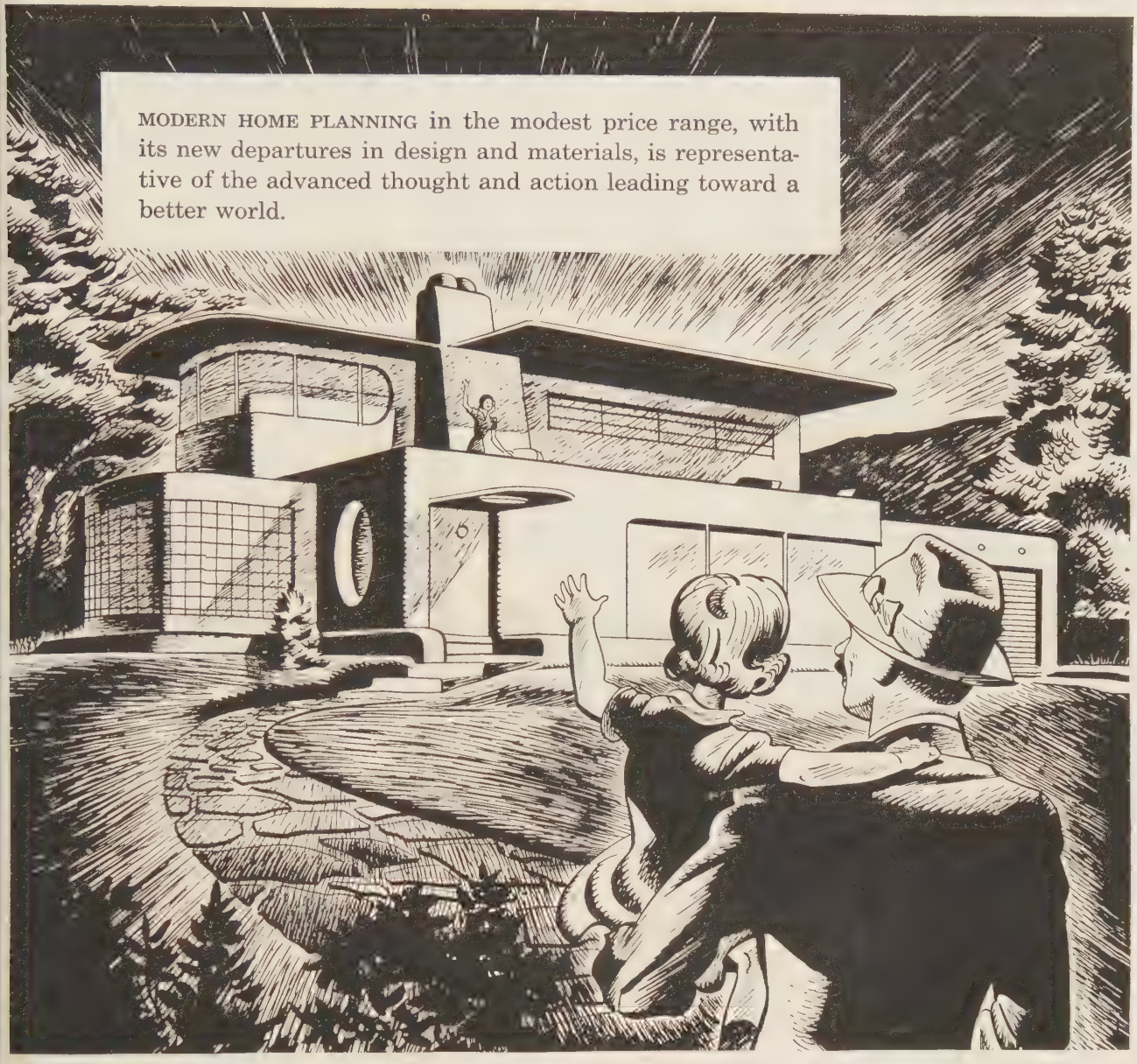
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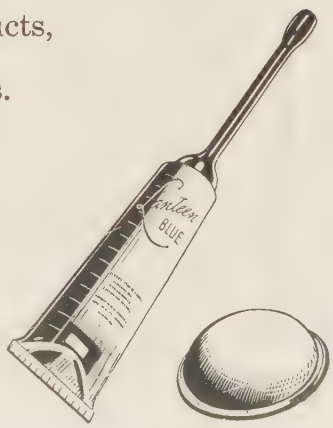

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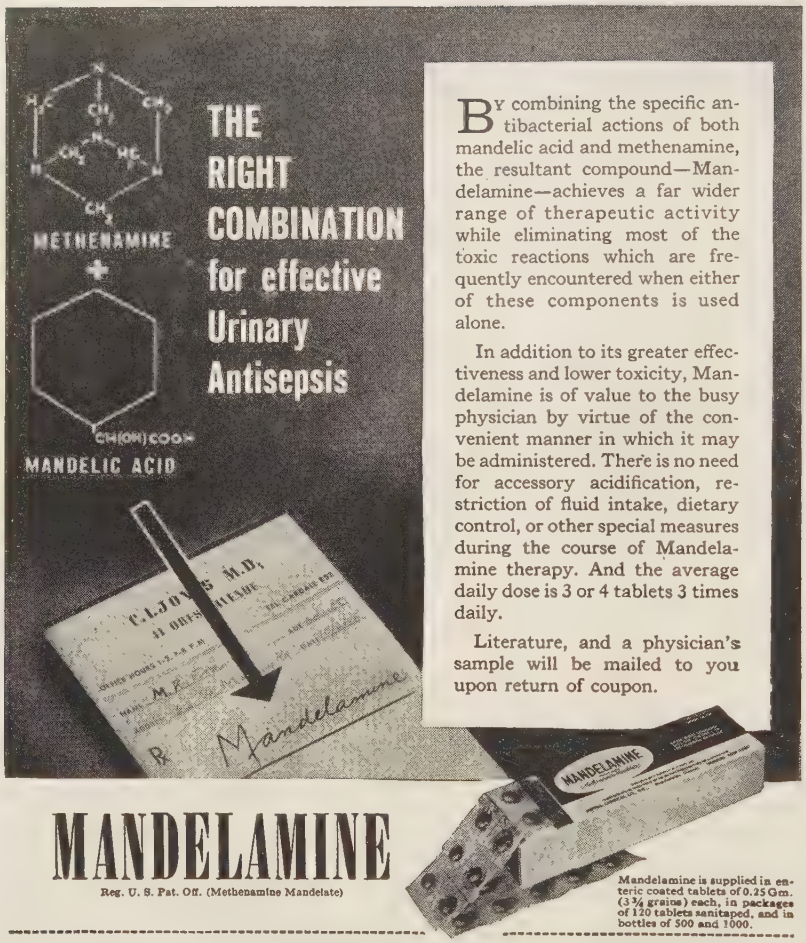
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Nutritional Aspects of Beer

How malt beverages can meet a portion of the daily dietary requirement by augmenting other foods, is told by Dr. Bruce Carlton, a chemist, who says (*American Brewer,* September, 1944) that a major factor in the amount a person will eat or drink is the psychological effect the food has on the person. Nutritionists are becoming more and more aware of this desirable attribute in the preparation of food. Beer may be considered a pioneer in this angle of nutritional development. It stimulates the salivary glands, and the mild, bitter taste stimulates the gastric juices.

Over five percent of the total weight of beer is found to consist of carbohydrates. About four calories are obtained from one gram of carbohydrate. Thus, a twelve ounce bottle of beer, weighing approximately 350 grams, will be found to contain approximately eighteen grams of carbohydrates and, therefore, would have seventy-two calories from the carbohydrates alone. The total caloric content of a twelve ounce bottle of beer is approximately 175. In comparison, the total caloric value of twelve ounces of tomato juice is approximately seventy. Beer not only supplies the much-needed minerals, but also the water, to offset the actual water loss.

The author says that no claims are made for beer as a single provider of the daily requirements of some of the components of vitamin B complex, but if three twelve ounce bottles of beer were consumed daily, an appreciable amount of the minimum daily requirements of the B vitamins would be supplied, a fact not hitherto recognized. Beer is not presented as a vitamin panacea, but it is offered as one of the few highly palatable vitamin-containing beverages.

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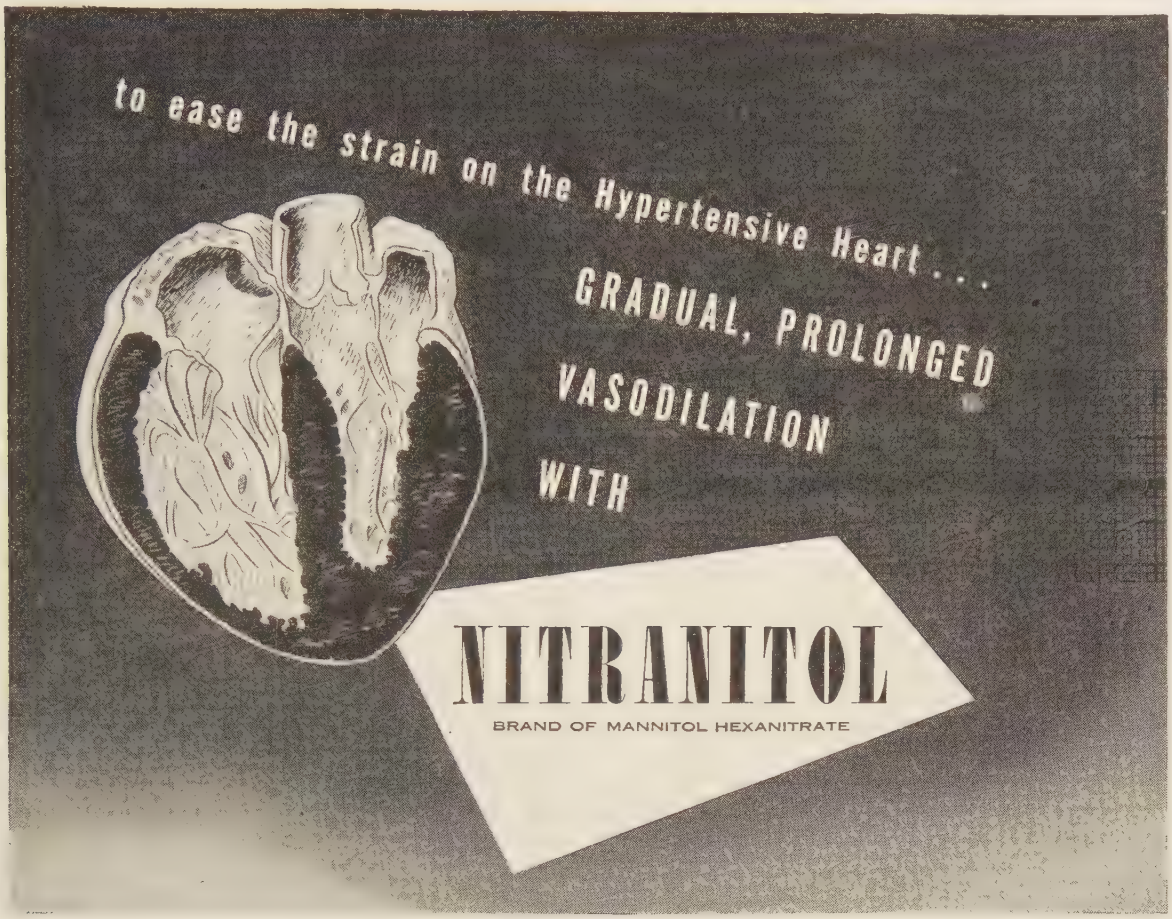
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Pneumonology

Milton Sills Lloyd *(N. Y. State Jour. Med.,* Jan. 15, 1944) looks upon tuberculosis in any selected community as a two-ring circus. Ring I, the house infection group, provides a constant supply of new far-advanced cases to Ring II, the supervised group. Here concentrated work with excellent results has been done, but regardless of this, the situation will remain unchanged until the source of supply in Ring I is successfully attacked. This brings up the question of the relative importance of preventive and therapeutic activities. His recommendations are concisely summed up as follows:

1. We know how to prevent and how to treat tuberculosis. Our failure to make better progress lies in a faulty organization—an "inability to choose".

2. Workers on tuberculosis complain justly of late diagnosis and insufficient hospital beds.

3. Early diagnosis is being obtained as a by product of the war. It can be completed by enlisting the services of the general practitioner, and the "bed" problem can be met by carrying the work to the people in the general hospital and the home.

4. The intensity of medical activity must be equally divided between the fields of therapeutic and preventive medicine. A new classification of tuberculosis, based on public health requirements, must be worked out. Enforcement of the sanitary code in regard to tuberculosis should be insisted upon by health authorities.

5. To accomplish this the general practitioner must be given training in tuberculosis and a share in antituberculosis work equal to the part which he plays in other fields. The lung specialist must be given the opportunity of rendering his service to, and earning a living in, a small community.

6. A new specialty, "pneumonology", including all modern methods of diagnosing and treating thoracic disease, must be established and gradually built up in every general hospital. This does not increase the tendency toward specialization, but on the contrary, would turn the three "specialties"—tuberculosis, bronchoscopy and thoracic surgery—into one and give them their proper position in organized medicine.

7. This would carry the antituberculosis work to all the people and a full scale campaign would be under way.

Lloyd concludes that the greatest opportunity likely to occur in this century is now with us. By intelligent organization a victory can be won over tuberculosis without the expenditure of money and without diverting attention from the war effort.

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The lives of thousands of tropical workers in essential war needs are being safeguarded by snake-bite serums and other vaccines produced on Brazil's famous "snake farm", the Butantan Institute, near the city of São Paulo. Poisonous snakes, toads, spiders, centipedes and other insects are among the many hazards faced by rubber gatherers in the forests of the Amazon, by farmers, and by workers in newly developed industrial areas. The serums are widely distributed throughout the nation in sections where they are most needed, and as a result, the mortality resulting from treated cases of snake bite has been reduced from twenty to twenty-two percent to from two to five percent.

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New Sedative-Antispasmodic

Hoffmann-La Roche, Inc., of Nutley, N.J., recently announced to the medical profession a new, superior sedative-antispasmodic called Syntronal, which has a threefold effect in all disorders associated with smooth muscle spasm and nervous tension. It selectively inhibits the parasympathetic terminations in smooth muscle but in contrast to atropine it is not likely to cause undesirable side reactions; it also has a direct relaxing effect on spastically contracted smooth muscle fibers, and it relieves nervous tension and apprehension which are often significant factors in spastic disorders. Syntronal may be prescribed with complete confidence in all disorders in which smooth muscle spasm is responsible for pain and functional disturbances. It is available in sugar-coated tablets, bottles of thirty and one hundred. Each tablet contains fifty mg. of Syntropan 'Roche' (phosphate of d, 1-tropic acid ester of 3-diethylamino-2, 2-dimethyl-1-propanol) and fifteen mg. of phenobarbital.

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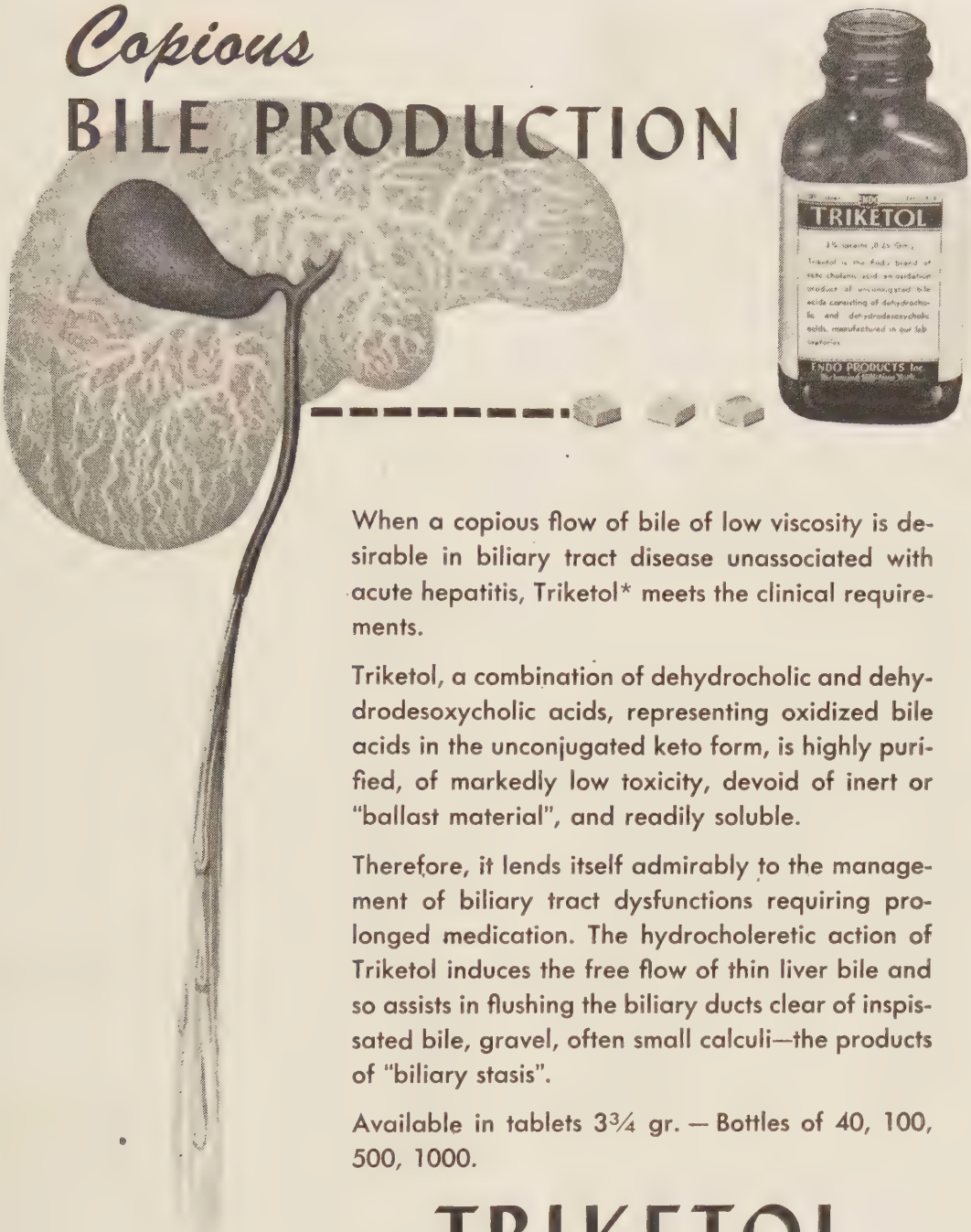

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International and Spanish Speaking Association of Physicians

At a meeting of the chapter Magnum of the International and Spanish Speaking Association of Physicians, held in New York on Friday, March 23d, the guest of honor was the Hon. Sr. Alfonso Grez, consul general of Chile. He brought with him a letter to Dr. Gershberg from His Excellency Don Juan Antonio Rios, president of Chile, in which he stated his willingness to act as an honorary president of the association. Communications from Professor E. Huntington of Yale, Bruno Walter, and Professor Łebedenko of U.S.S.R., were also read and seventeen new members were elected. The scientific program consisted of a symposium on "Romance of the Professions Here and In Latin-America". Prof. George Draper, of Columbia University, spoke on the romance of medicine; Prof. C. W. Ballard, Phar. D., dean of the College of Pharmacy, spoke on the romance of pharmacy; and A. Lehman, D.D.S., of Hollywood spoke on the romance of dentistry. At the reception, held at the home of Dr. Gershberg, refreshments were served and Miss Christine Carrol, Metropolitan Opera soprano, entertained.

A complete list of the officers of this association which have been elected to serve for the year 1945 are as follows: President, J. M. Gershberg, M.D., New York; first vice-president, Prof. Ray Lyman Wilbur, San Francisco; second vice-president, Prof. J. R. Goodall, Montreal; third vice-president, Prof. J. A. Sacasa, Nicaragua; general secretary, Dr. William B. P. McDonough; general treasurer, Dr. Frederick S. Aron; assistant secretary, Dr. Julius Hayn; assistant treasurer, Dr. Albert Keesing; recording secretary, Dr. E. F. Dupré; corresponding secretary, Dr. F. E. Gillespie; legal advisor, Judge M. Strasburger, Esq. H. Gillespie; legal advisor, Judge M. Strasburger, Esq. Chairmen: Board of directors, Prof. George W. Henry; advisory council, Prof. George Draper, scientific research, Prof. Angel H. Roffo; executive board, Prof. Edgar Meyer; Latin-American relations, Prof. Alberto Isquirdo; medical committee, J. H. Heacock, M.D.; dental committee, Frank Adam, D.D.S.; pharmaceutical committee, C. W. Ballard, Phar. D.

Abstract of Dr. Gershberg's Presidential Address

Your Excellency, officers, members of the International and Spanish Speaking Association of Physicians.

Tonight, when we are celebrating our nineteenth annual meeting, my feelings do not permit me to suspend the deep acknowledgment of that debt of gratitude, which I owe to you for the honor again conferred upon me in reelecting me as your president for 1945. Still more, I appreciate the confidence with which you have supported me while serving you as your president in 1944. I shall endeavor to carry on my work for the progress of our association during this year to the best of my ability and with your encouragement.

This war has for the present prevented the realization of our program for the progress of our association of which the four principal aims are:

First, to advance internationally the science of medicine and surgery.

Second, to promote universal peace which should guarantee the four freedoms so nobly laid out by our beloved president, Franklin D. Roosevelt, for the good of humanity.

Third, to put in practice the good will neighbor policy and especially with the physicians and surgeons of Latin America.

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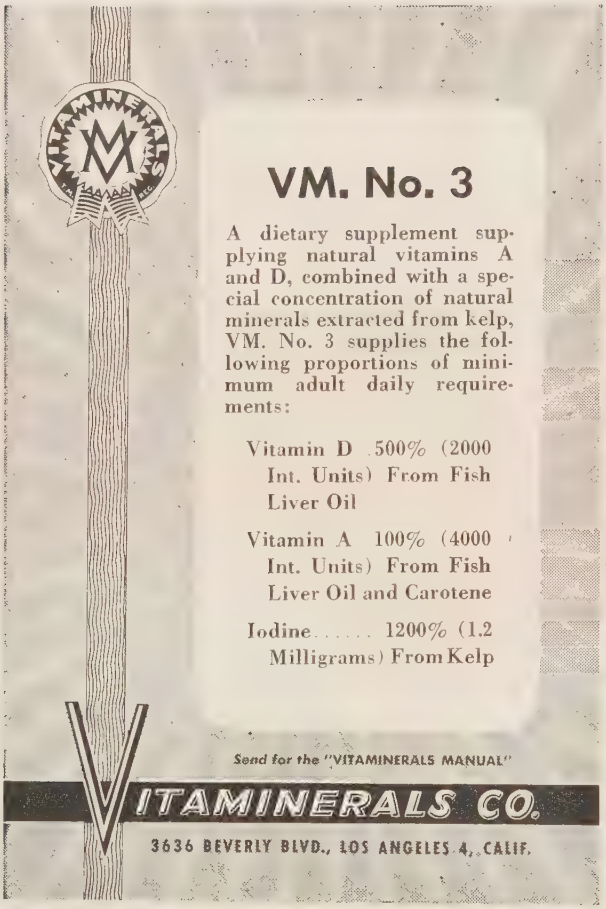
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Fourth, to establish an international hospital in New York City free from racial and religious prejudices.

I assure you that after this bloody war is over, our keen interest will be to take care of these four aims, and with your support, we can and we will do all possible for the realization of all the plans of the International and Spanish Speaking Association of Physicians.

Ladies and gentlemen, May I report to you that nearly forty percent of our members are serving in the army, navy, air corps, etc., and that we are very proud of them. Our members who have fallen on the field of honor, we revere as real patriots. After the suppression by the chapter magnum, of more than twenty chapters in the countries at war, we have replaced them with new chapters in our own country, as you have heard read in the annual reports of the secretary and the chairman of the Board of Directors. We now have forty-six chapters in our association.

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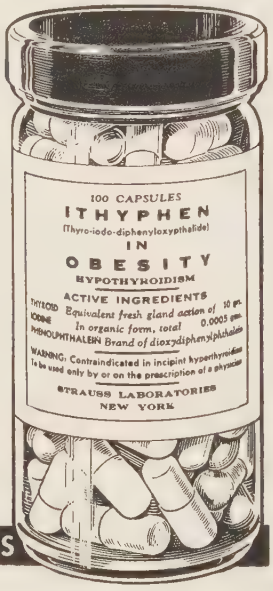

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Venereal Disease in Panama

The fight against venereal disease among the troops of the Panama Canal Department has been highly successful, according to the annual report for 1944 recently issued by Col. Wesley C. Cox, venereal disease control officer of the department, which shows a new low rate of 2.09 percent. This rate is less than one-half of the previous annual low of 4.27 established in 1943 and considerably under one-third of the 6.6 percent recorded in 1940, the first year in which large-scale control campaigns became necessary. Contributing to the 1944 record low was a rate of 1.4 percent attained in the final month of the year. Reports for the first two months of the present year show a still further decline to a rate of 1.8 percent. Contributing to this favorable average, which is substantially lower than that for the continental U.S., is the cooperation between health officers of the Army and the Republic of Panama, in a thorough program which eliminates sources of infection.

In an organized program of instruction of troops, the deleterious effects of venereal disease upon mental and physical faculties are pointed out, also the need for and value of moral cleanliness in the present war effort. Control of venereal disease is made a responsibility of command under the Army program.

Brigadier General Henry C. Dooling, chief health officer of the Panama Canal Department, acts as liaison officer between the Army and the civil authorities. Dr. Guillermo Paredos, director of public health, works with General Dooling in connection with government cooperation in the campaign against venereal disease.

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Abortion

J. Rock, of Brookline, Mass. (*New England Jour. Med.* 223:1020, 1940), considers the entire subject of abortions under the following headings: frequency, etiology, prophylaxis, process of abortion, treatment, and complications. Under etiology endocrinopathies are discussed. Estrogens must condition the fallopian tubes so that correct peristalsis will ensure transport of the blastocyst. The endometrium must be properly prepared by estrogen and progestin. Progestin also quiets the myometrium, particularly in later stages of pregnancy. Since violent emotions are known to precipitate miscarriage it is probable that the thyroid and adrenal glands are implicated in the bleeding mechanism. The value of thyroid in overcoming sterility is mentioned. None of the preparations of anterior pituitary hormone is of value in protecting human pregnancy.

The spontaneous cure rate among women who have had previous abortions is so high as to mislead the less perspicacious among therapeutists. Malpas found that sixty-two percent of women who had aborted twice carried the third baby to term without specific treatment, and that thirty-five percent of twenty-five women who had aborted three times delivered their fourth pregnancies at term.

Possibly the greatest value of treatment in habitual abortion is during the month of conception rather than later. Until we know more of the physiology of pregnancy and of the first causes of abortions it is reasonable to continue to use progesterone during the first half of pregnancy, or longer in some cases, if previous pregnancies have terminated in miscarriage.

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Clinical Use of Chemotherapeutic Agents

At a meeting of the Society of Medical Jurisprudence, held at the New York Academy of Medicine, Monday evening, April 9th, Dr. C. Harrison Snyder, instructor in pediatrics at the College of Physicians and Surgeons, Columbia University, read a paper on "Penicillin and Other Chemotherapeutic Agents, Their Clinical Use, Limitations, and Harmful Effects, and Some Legal Problems Involved in Their Use". The author pointed out that with penicillin now commercially available, and with the prospect of its being administered by mouth, by inhalation, or in ointments, nose-drops and lozenges, it was important for all those concerned in medical practice to be familiar with its nature and use, its limitations and harmful effects. It was also time to decide, he said, what legal restrictions should be applied to the preparation and distribution of the drug, and he presented certain pharmacological, bacteriological, and clinical data on which to base an opinion as to what legal controls were necessary. The less known antibiotics, tyrothricin, streptothricin, and streptomycin were mentioned briefly, as well as the recent use of sulfonamides in the armed forces for prophylaxis against upper respiratory infections. Mention was also made of thiouracil, its indications and harmful effects. An interesting discussion took place, which was opened by George B. Schoonmaker, Esq., Frank A. Calderone, M.D., Deputy Commissioner, Department of Health, New York City, and Charles E. Dutchess, M.D., medical director, Schenley Laboratories, Inc., producers of penicillin.

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Psittacosis in the United States

G. L. Dunnahoo and Brock C. Hampton (*Public Health Reports,* March 30, 1945) say that psittacosis infection in the Western Hemisphere probably originated in the tropics, where the disease is endemic among birds of the psittacine family. It has at times become rather widely distributed in the United States. Human cases were probably first reported in this country by Vickery and Richardson in 1904. The first extensive outbreak in the United States was that of 1929-30, in which seventy-four foci of infection were recorded, which gave rise to 170 reported cases with thirty-three deaths during the period November 23, 1929, to December 31, 1930. These cases were distributed in sixteen States and the District of Columbia and are exclusive of sixteen laboratory infections, with two deaths, and of twelve probable cases which were removed from two merchant ships that entered United States ports. In these latter cases the patients were exposed aboard ship to parrots which had been purchased in Germany and Brazil. During the period 1931-42, inclusive, there were 210 cases reported in the United States, with forty-seven deaths, seventy-four of these cases occurring in 1932. The total number of cases of psittacosis reported in the United States from 1929 to 1942 was 380, with eighty deaths.

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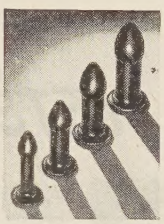

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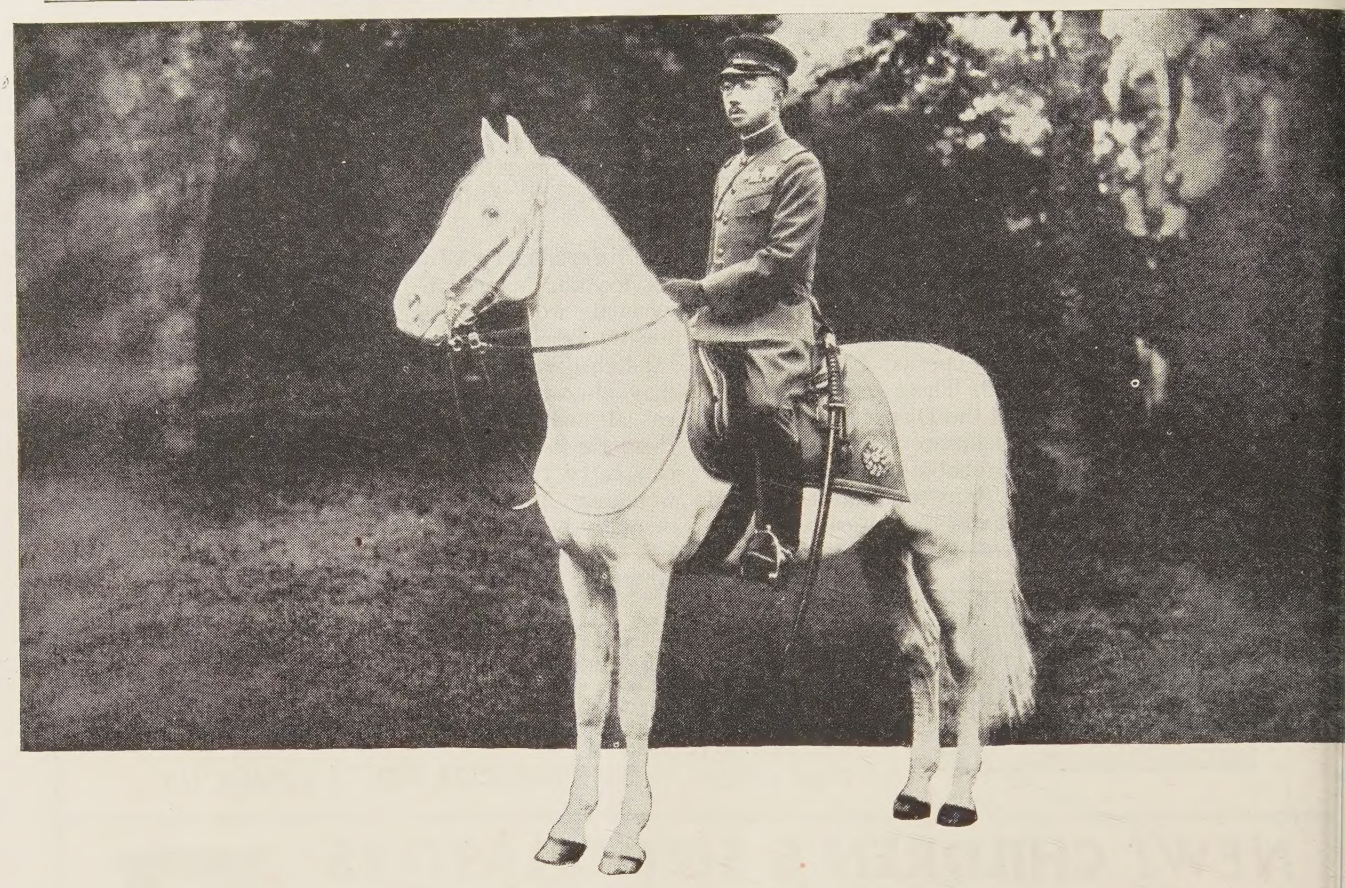

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